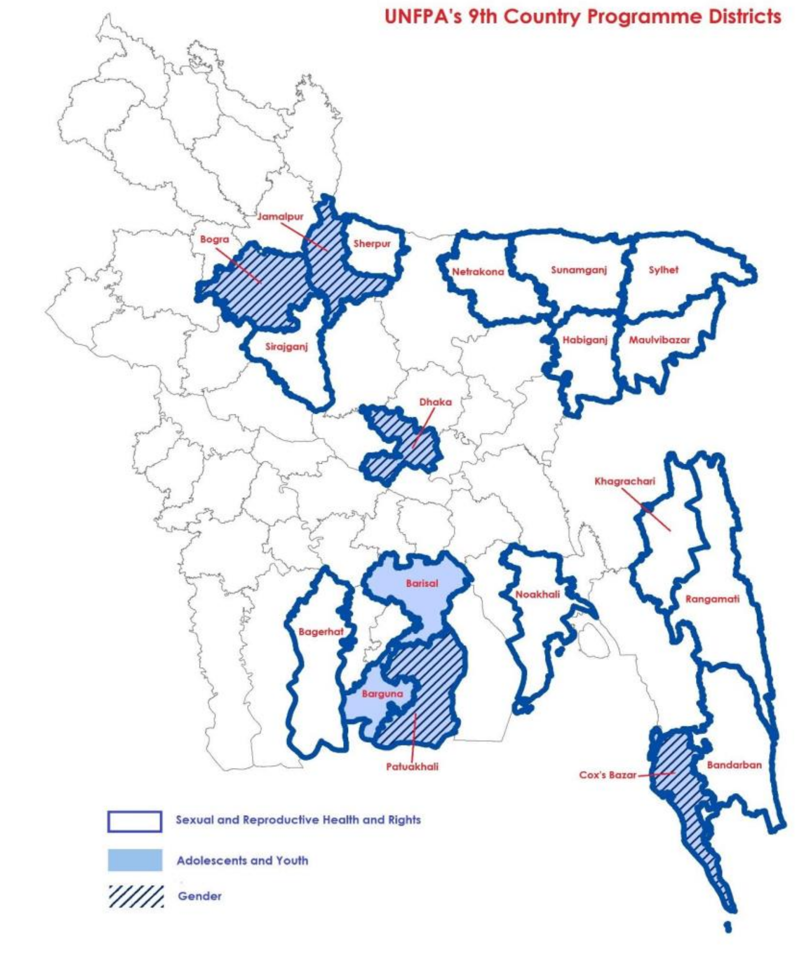
EVALUATION OF THE UNFPA 9TH COUNTRY PROGRAMME OF ASSISTANCE TO THE GOVERNMENT OF BANGLADESH

CPE Final Report

December 30, 2019

Bangladesh Country Map



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Disclaimer: This is a product of the independent evaluation by the above team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States. The report is not professionally edited.

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Abbreviations and Acronyms

24/7	Coverage of services 24 hours a day, 7 days a week
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APRO	Asia Pacific Regional Office
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual Reproductive Health
A&Y	Adolescent & Youth
ASK	Ain O Salish Kendra
AWP	Annual Work Plan
BBC	British Broadcasting Corporation
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BGMEA	Bangladesh Garment Manufacturers and Exporters Association
BMS	Bangladesh Midwifery Society
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination of Against Women
CERF	Central Emergency Response Fund
CMR	Clinical Management of Rape
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Program Evaluation
CO	Country Office
CWFD	Concerned Women for Family Development
DFID	Department for International Development (UK)
DGFP	Directorate General Family Planning (MoHFW)
DGHS	Directorate General Health Services (MoHFW)
DGNM	Directorate General Nursing and Midwifery MoHFW)
DH	District Hospital
DHS	Demographic Health Survey
DIFE	Department of Inspection and Factories and Establishments
DSHE	Directorate of Secondary and Higher Secondary Education
DWA	Department of Women's Affairs
DYD	Department of Youth Development
EmOC	Emergency Obstetrics Care
EmoNC	Emergency Obstetrics and New Born Care
ERG	Evaluation Reference Group
FGD	Focus Group Discussions
FP	Family Planning
FWV	Family Welfare Volunteer
GBSS	Gender-based Sex Selection
GBV	Gender-Based Violence
GBViE	Gender-based Violence in Emergencies
GBVSS	Gender Based Violence Sub Sector
GE	Gender Equality

GED	General Economics Division
GEWE	Gender Equality and Women's Empowerment
GOB	Government of Bangladesh
GUK	GonoUnnayon Kendra
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPNSDP	Health Population and Nutrition Sector Development Plan
HR	Human Resources
IASC	Inter-Agency Standing Committee
ICM	International Confederation of Midwives
IEDCR	Institute of Epidemiology, Disease Control and Research
IOM	International Organization for Migration
IPs	Implementing Partners
ISCG	Inter-Sectoral Coordination Group
IUD	Intra-Uterine Device
KII	Key Informant interviews
LARC	Long Acting Reversible Contraceptive
MCH	Medical College Hospital
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MIS	Management Information System
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoFA	Ministry of Foreign Affairs
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
MPD	Maternal and Perinatal Death
MPDSR	Maternal and Perinatal Death Surveillance and Response
MTSP	Mid-Term Strategic Plan
NAP	National Action Plan
NEX	Nationally Executed
NA	Not Available
NASP	National AIDS/STD Programme
NCTB	National Curriculum and Text Book Board
NGA	National Government Agency
NGO	Non-Governmental Organization
NGOAB	Non-Government Organization Affairs Bureau
NIPORT	National Institute of Population Research and Training
NLASO	National Legal Aid Services Organization
NM	Nursing and Midwifery
NNPC	Nari Nirjaton, Protirodh Committee
NPC	National Population Council
NSO	National Statistical Organization
NSDAS	National Skills Development Authority Secretariat
NVD	Natural Vaginal Delivery

ODA	Official Development Assistance
OECD	Office of Economic Cooperation and Development
PAC	Post-Abortion Care
PCA	Programme Coordination Activity
PD	Population and Development
PLHIV	People Living with HIV
PO	Programme Officer
PPFP	Post-Partum Family Planning
PPH	Post-Partum Hemorrhage
PWD	People with Disabilities
Q	Quarter
RTMI	Research Training and Management International
SBCC	Social Behavior Change Communication
SCF	Save the Children's Fund
SCI	Save the Children International
SDA	Society Development Agency
SDGs	Sustainable Development Goals
SFYP	Seventh Five year Plan
SI	Sub Inspector
SOPs	Standard Operating Procedures
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health & Rights
STI	Sexually Transmitted Infection
TAPP	Technical Assistance Project Proforma
TBA	Traditional Birth Attendant
TBD	To Be Decided
TOR	Terms of Reference
UCEP	Underprivileged Children's Educational Programs
UHC	Upazila Health Complex (DGHS)
UH&FWC	Union Health and Family Welfare Centre (DGFP)
UN	United Nations
UNCT	United Nation Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
UNWomen	United Nations Women
VAW	Violence Against Women
WB	World Bank
WFS	Women Friendly Space
WHD	Women Help Desks
WHO	World Health Organization
YPSA	Young Power in Social Action

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Box 1: Structure of the Bangladesh country Programme Evaluation (CPE) Report:
This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook issued by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction,** provides the background to the evaluation, objectives and scope, the methodology used, including the limitations encountered, and the evaluation process. The **second chapter** describes the Bangladesh country context including the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in sexual and reproductive health, adolescents and youth, gender equality and population and development areas. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (attached); the **fifth chapter** discusses conclusions and the **sixth chapter** concludes with recommendations under strategic and programmatic level, based on the conclusions.

Two types of Annexes: Annexes 1-5 contain the required (obligatory) documents for CPE. Due to CPE page limit and the size of Bangladesh country programme, details on findings are not included in the main report. Annexes A-H provide additional information on relevance, performance, programme intervention logic, UNFPA coordination role, stakeholder map and others that may be useful to the country office, other interested readers and as input to future evaluations.

Table 1: Key Facts and MDG Progress

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. 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. Vulnerable to natural disasters, further exacerbated by climate change, the country ranks (based on World Risk Index) fifth highest disaster risk country in the world and second in Asia.
Land area	147,570 km²
Terrain	Mostly flat and hilly in the southeast
People	
Population	168.1 million (State of the World Population, 2019)
Urban/ rural ratio	23 /77 (Population and Housing Census, 2011)
Total Fertility Rate	2.3 (Bangladesh Demographic Health Survey, 2017)
Government	
Type of government	A parliamentary representative democratic republic with government headed by the prime minister
% of seats held by women in national parliament	12% (43 out of 350)

Economy	
GDP per capita	GNI per capita $1,827 in FY2018-2019 (BBS, 2019)
GDP Growth rate	7.9% in 2018 (Asian Development Bank, 2019)
Main industries	Textile, farming, energy, construction
Social indicators	
Human Development Index Rank	136th rank with HDI 0.608 in 2017 (UNDP, 2019)
Gender Inequality Index Rank	134th rank with GII 0.542 in 2018 (UNDP, 2019)
Gender parity in tertiary education (GPI)	0.701 (GED, 2016)
Adult literacy rate (15+ years)	52.96 (Census, 2011)
Unemployment rate	4.4 (ILO, 2017)
Youth not in education, employment or training (NEET)	28.9 (LFS 2015 – 2016)
Life expectancy at birth	72.8 (World bank, 2017)
Under-5 mortality (per 1000 live births)	45 (Bangladesh Demographic Health Survey (BDHS), 2017)
MMR	196 (Bangladesh Maternal Mortality and Health Care Survey, 2016) (and 176, SWOP, 2019)
Health expenditure (% of GDP)	10 (World Bank, 2016)
% of births attended by skilled health personnel	53% (Bangladesh Demographic Health Survey, BDHS,2017)
Antenatal care coverage by at least 4 visits	47% (BDHS, 2017)
Percent of births delivered by C-section	33% (BDHS, 2017)
Adolescent birth rate	113 (BDHS, 2014)
The proportion of women age 15–19 who have begun childbearing	28 (BDHS, 2017)
Contraceptive Prevalence Rate	62 (BDHS, 2017)
Unmet need for family planning	12 (BDHS, 2017)
Percent of women aged 20–24 who were married before age 18	59 (BDHS, 2017)
Median age at first marriage	16.3 (BDHS, 2017)
% of people living with HIV, 15-49 years old	<0.1 (UNAIDS, 2017)
Millennium Development Goals (MDGs): Progress by Goal (details could go in the Annex) (Mention On track or off track, give a brief description in one or two sentences) Source:	
1 - Eradicate Extreme Poverty and Hunger	y met: targets 1.1a, 1.2, 1.8 are met, but 1.1 and 1.5 are not met. Some indicators lack targets and/or data: 1.3, 1.3a, 1.4, 1.6, 1.7, 1.9
2 - Achieve Universal Primary Education	y met: target 2.1 is met, but 2.2, 2.3, 2.3a are not met.
3 - Promote Gender Equality and Empower Women	y met: targets 3.1a, 3.1b are met. 3.1c, 3.2 and 3.3 are not met.
4 - Reduce Child Mortality	y met: targets 4.1, 4.2 are met. Targets 4.3 note met.
5 - Improve Maternal Health	Not met.
6 - Combat HIV/AIDS, Malaria and other Diseases	Partially met: target 6.1 met, target 6.5 not met. No data for other targets.

Executive Summary

Background: The ninth Bangladesh Country Programme (CP9), implemented in cooperation with the national and local government partners, UN agencies, donors, INGOs and NGOs, consists of four strategic outcome areas, namely, Sexual and Reproductive Health and Rights (SRHR); Adolescent and Youth (A&Y), Gender Equality and Women's empowerment (GEWE) and Population Dynamics (PD). CP9 (2017 – 2020) spans two SPs 2014-2017 and 2018-2021, with a budget of USD 52.6. In line with UNFPA Evaluation Policy, an independent evaluation of the country programme is being conducted in 2019.

The purpose of the Country Programme Evaluation (CPE) is to demonstrate accountability to stakeholders on performance achieved; to support evidence-based decision-making; to contribute, important lessons learned to the knowledge base of the organization; and, in turn, to provide independent inputs to the next UNFPA country programme (CP) cycle and the strategic direction of the continued role for UNFPA support to the Government of Bangladesh. **The audience** of this evaluation is the UNFPA Country Office (CO), Regional Office, HQ and the UNFPA Executive Board; national partners, relevant government agencies, other development partners including the donors, and UN agencies in the country.

The specific objectives of the CPE are to: (a) provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability of the approaches adopted by the current CP; (b) provide an assessment of the CO's strategic positioning within the development community and national partners; and (c) draw key lessons from past and current cooperation and provide strategic and actionable recommendations for the next CP. The **scope** is to evaluate the initiatives implemented from 2017 to mid- 2019 under the four outcomes and seven outputs given below. CP9 covers 19 districts based on selection criteria.

Interventions under Sexual and Reproductive Health and Rights (SRHR), Adolescents & Youth (A&Y), Gender Equality and Women's Empowerment (GEWE) and Population and Development (P&D)[1] were evaluated applying Relevance, Effectiveness, Efficiency, and Sustainability as well as Coordination criteria specific to UNFPA evaluations. While humanitarian response is mainstreamed into the four outcome areas, Coverage and Connectedness criteria are assessed for the Humanitarian assistance.

Methodology: The evaluation, divided into design, data collection and analysis and reporting phases, was structured based on the above mentioned seven evaluation criteria. After the design of the evaluation was approved by the country office (CO) and the Asia Pacific Regional Office (APRO), data collection was done. Applying purposive sampling method, mixed method approach for data collection from both secondary and primary sources were used. This included documentary review; monitoring and evaluation (M&E) data review; financial and operations system review; structured and semi-structured interviews, face-to-face, individual and group interviews; observations and an attitudinal survey. Triangulating the sources and methods of data collection, the evaluation adopted an inclusive approach, involving a broad range of partners and stakeholders. Totaling about 400, with 54% being female respondents, UNFPA CO staff, national and local level development partners, UN Country Team (UNCT), service beneficiaries and providers, contributed their input to this evaluation. Validation of the preliminary findings was done by presentation of the results first to the CO and then to a broader stakeholder group including the evaluation reference group (ERG). A second workshop, with

[1] Population Dynamic (PD) is defined as an area of work that Population and Development (P&D) component does or UNFPA should do to achieve universal access to SRH. Thus, in this report the Unit that delivers the work in the country office is referred to as P&D, and its area of work or function is referred to as PD.

government and non-government IPs, donors and key development partners, was held to validate and disseminate the final findings, conclusions and recommendations.

Main Conclusions: Keeping in line with national priorities, interests, and policies, the International Conference on Population and Development Programme of Action (ICPD POA), strategic plans and mode of operation, CP9 stays relevant to the country priorities, UNFPA mandate, United Nations Development Assistance Framework (UNDAF), and the needs of the targeted beneficiaries. With the alignment of the Strategic Plan (SP) in 2017, CP9 shifted its focus, gradually and successfully, from direct service delivery to strengthen institutional capacity and systems, establishing and expanding strategic partnerships to leverage resources. Increased emphasis on high-level policy advocacy, capacity building, catalytic work, and establishing strategic partnerships have provided effective and replicable programme models as evident from the evaluation findings.

Based on the interventions and programme area selection process, CP9 has a clear focus on vulnerable and marginalized groups. However, still some data gaps remain in this area that may limit more targeted interventions contributing to the goal of “no one left behind.” The programme design has followed a clear theory of change (TOC) for individual outcome areas; however a comprehensive TOC depicting the linkages of the entire CP9 was not available.

Being a knowledge broker, advocate and partner, UNFPA has been successful in bridging various players engaged in the development field. Advocating for SRHR, ASRH, GEWE, providing quality data for evidence based planning and policy making, and providing access to information and knowledge as a human right, CP9 implementation has employed gender-accommodating and human rights-based approach. Strategically, UNFPA has maintained its strong presence in all policy and key decision functions related to UNFPA’s mandate. UNFPA’s corporate strengths are well recognized and acknowledged by other UN members for the contribution in improving the UNCT coordination mechanism. Using its comparative advantage and taking the lead in advocating for sensitive issues on human rights, adolescent SRH (ASRH), GBV, FP and HIV prevention, UNFPA has promoted creativity and innovation through embarking on non-traditional areas such as midwifery, prevention of harmful practices for girls, and ASRH. While UNFPA has started nascent initiatives, there is room to lobby stronger on rights issues and male engagement in SRHR where the government agencies are weak in promoting related interventions, formulating policies and/or implementing current policies. As a development partner, UNFPA is valued for the technical assistance it provides to the country. UNFPA has established sustainable and strategic partnerships, especially in the PD area, enabling a conducive environment (at a higher level) to lobby for areas such as stopping child marriage and sexual health rights, violence against women (VAW) that are culturally sensitive and deep-rooted making them difficult to change.

Country Office, with its reduced resources, both human and financial, and amid several major emergency situations, has managed to achieve most of the planned results in the CP9 implementation in this short country programme cycle. Given the reduced funding environment for CP9 and perhaps for CP10, diversifying resource mobilization approaches, beyond traditional donors, will be an added role for the CO. Office built effective partnership with the donors by establishing confidence in providing technical expertise and trust in the management of financial resources, however given the competitive environment for the same pool of funding UNFPA has more room to be innovative in resource mobilization. Expansion of partnership to private business groups is limited/weak and is a potential area to be explored.

As stated, despite interruptions due to humanitarian crises and the strategic changes in the mode of programme implementation in the first year of the cycle (2017), CP9 has achieved most of the planned results, as evident from results discussed in the report in all outcome areas, with the exception to A&Y outcomes which suffered the most due to delay in funding approval. In programme implementation, project funds were released at a foreseen level in the work plans (WPs), however, fund releases to IPs had been delayed in few cases, mainly due to the complicated and less flexible UNFPA financial procedures and government financial procedures in approval of proposals, like technical assistance project performa (TAPP), indicating a need for simplified approval procedures and well-coordinated disbursements of funds for more efficient and timely operation.

UNFPA is the key UN agency that provides technical support relating to generation of quality data for evidence based planning. Working with strategic partners, most of the initiatives of CP9 are likely to be sustained for a long time as the establishment of policies, laws, acts and procedures have been in consultation with the government keeping line with its system and needs. Somewhat inadequate attention paid to population dynamics as a macro-level variable in development could diminish the value of integration of population data in development planning and the larger role that UNFPA can play in the overall macro level national development. Similarly, bodies such as National Population Council (NPC) that can advocate for population matters seem to be not fully functional and influential in pushing the population policies forward. UNFPA's initiative to advocate for harmonization of all demographic surveys is a good move, but further follow up is essential for results to be realised.

The national as well as district level institutions expressed the need for continuous engagement with UNFPA for technical assistance. It was evident that the continuity of the interventions through several CP cycles has brought sustainable results, as observed in the results. CO has established a well-functioning and user friendly M&E system. However, an area with gaps is the measurement of behavior change. Several key interventions include behavior change – at individual and institutional level, but there are limitations to evaluating these due to the gaps in the measurement issues.

While Bangladesh is classified as a "red country," the mode of operation had been shifting its focus from service delivery and individual-focused capacity building interventions to more of institutional capacity-building, technical assistance and strategic policy advocacy/advice types of support resulting in the generation of knowledge products on PD, SRH, FP, GE, A&Y and demographic dividend among others, serving as evidence for more informed policy making and program planning at the national and local levels. Urban health, a new area for UNFPA, will need strong cooperation across UN partners, government agencies, UNFPA programme staff of all outcome areas, other relevant NGOs and CSOa for successful planning and implementation.

Service delivery exists in the humanitarian assistance, health sector, and piloting of new interventions. Preparedness aspects of humanitarian response are still being improved and further strengthening of preparedness would minimize the strain on the development agenda as the human resource capacity is limited. With the change in role, from service provision to advocacy and technical assistance, CO staff profile has not changed much. However, the evaluation results prove that UNFPA has been able to achieve sustainable key results in the mandated areas despite shrinking budget and current human resources. Resource mobilization and maximizing the UNFPA comparative advantage are considered increasingly important in the resource-constrained environment, and CO human resources dedicated to promote these aspects are limited. UNFPA is considered a friendly and accommodating agency and almost all development partners expressed their willingness to collaborate with UNFPA in the development interventions.

Recommendations: At strategy level, continue to strengthen the strategic partnerships with key government and non-government agencies. Given the mode of engagement and programming needs, UNFPA should maintain its leadership in assisting the government with strategy and policy development, advocacy role and technical assistance where necessary. Continue with innovative interventions (e.g., the use of parliamentarians to lobby for sensitive issues that are within UNFPA mandate that will contribute to long-term results beyond this CP cycle) that encompass all UNFPA programmatic areas and multiple implementing and development partners. A clear and stronger advocacy strategy to fully utilize the generated population data for policy making and planning by high level decision makers at all levels. To enhance full and effective implementation of the policies, UNFPA to lobby and advocate for functionality of relevant departments and agencies (e.g. National Statistical organizations, NPC etc.).

CP10 should follow an integrated programming approach across development programme components in the design of CP10 interventions, ensuring adequate skills and capacity of staff that participate in formulating the results framework. Advocacy and policy dialogue/negotiating, lobbying, and advising role will be the major focus of UNFPA's development agenda in CP10, thus the need for targeted HR capacity building plan for high quality technical assistance for this transition. A few key capacity development initiatives implemented in CP9 (harmonization of surveys, generation of quality knowledge products, knowledge management and follow-up on demographic dividend (DD) initiative) will form part of CP10 as well. These initiatives are multifaceted, that cut across all UNFPA mandated programme areas (SRHR, A&Y, GEWE and PD), necessitating to work with multi-stakeholders and/or new partners. UNFPA's niche working with parliamentarians should receive more attention and strengthen it as a key focus.

Population dynamics (PD) and changing demographic structures including their distribution have tremendous bearing on macro social and economic development processes and outcomes. UNFPA should lobby for population dynamics to be given emphasis as a macro-level variable in development, which also helps support, UNFPA interventions in SRHR, GEWE and AY. UNFPA population and development (P&D) unit should be given much more prominence than what it receives currently and PD should be the umbrella programme that cuts across all outcome areas and programmes. Continue UNFPA support to PD interventions with strategic partners advocating for evidence-based research, harmonization of surveys, employing strategic interventions to make quality data accessible and available for evidence based planning and policy making across all outcome/programme areas. Invest in understanding inequalities and disparities in marginalized and vulnerable groups for evidence-based resource allocation and the changing attitudes and behavior of population groups. Appointment of a chief for the P&D unit, at a level on par with General Economics Division (GED) senior member, should be a priority if UNFPA visibility is to be increased and sustained.

In CP9, still some secondary school-based interventions of the A&Y program have not been off the ground in many places due to delay in the TAPP approval, as observed in our field visits. Based on high demand from partners, team's observation and feedback from stakeholders, UNFPA's contribution of support for youth and adolescent Life Skills Education (LSE)/Comprehensive Sexuality Education (CSE) should be scaled up in more secondary schools with substantial funding support. Strengthen and develop the capacity in terms of understanding of adolescent responsive programming (on SRHR or other issues) of the Ministry of Women and Children Affairs, which is the nodal Ministry with the mandate for the development of women and children, is essential for the quality delivery of programming focusing on adolescent girls and boys. Support access of adolescents and youth to realize their SRH rights and have access to SRH services based on their needs.

Strengthen public health interventions and multi-sectoral interventions aiming to address Violence Against Women (VAW). This programme should focus not only on the role of men and boys as agents of change to promote GE and end violence but also recognize their vulnerabilities and needs in relation to GBV. GBViE should receive frontline attention and sustainability issues in the humanitarian sector must be explored to set an exemplary of transcending the humanitarian-development divide. Women's economic empowerment has long been considered a key ingredient in structural interventions to reduce gender equality and the experience of GBV amongst women and girls hence it is recommended to develop a UN Joint Programme to address these. Still there are some constraints in MNH implementation that needs to be addressed through focusing on the midwife led continuum of care, including aspects of training through faculty.

Develop a methodology for the analysis of the vast amount of monitoring data gathered in the SRHR outcome area, aimed to provide a basis to the development of evidence on what works and what does not in focus districts in the SRHR programme, in order to inform the next programme cycle. This can in particular be based on enabling of comparison of similar SRHR programming in different contexts as well as different SRHR programming in similar contexts. In this way the substantial investment made in the monitoring system could be used to provide evidence-based inputs to the development of the new country programme.

The programme could benefit from an overall Theory of Change for the entire country programme to develop a clear and shared understanding of how all parts of the programme fit together providing linkages across parts of the country programme. This will be timely given the preparation of United Nations Sustainable Development Cooperation Framework (UNSDCF) and to avoid any overlaps. Currently each individual programme outcomes are explained in separate TOCs. While a clearly laid out TOC, together with barriers and root cause analysis, could provide a useful starting point for the development of the overall programme strategy and results framework for the next country programme, it will be tremendously helpful also for resource mobilization as well, in addition to enhancing the effectiveness and efficiency of the programme.

The programme preparation in urban areas, including slums in Dhaka, may produce more effective and efficient outcomes if inputs from across the UNFPA outcome areas are sought. Linking such programming with the PD regarding analysis of data on urbanization trends and other relevant topics to inform the development of the programme and Joint programming in cooperation with other UN agencies will optimize the results. UNFPA to stay focused on its mandate and maximize on the corporate strengths and comparative advantage to maintain a high profile in the country, both in the development and humanitarian settings.

Chapter 1: Introduction

Implemented in cooperation with the national and local government partners, UN agencies, donors, national and International non-governmental organizations (NGOs and INGOs), and Civil Society Organizations (CSOs), the ninth Country Programme (CP9) consists of four strategic outcome areas, namely, Sexual and Reproductive Health and Rights (SRHR); Adolescent and Youth (A&Y), Gender Equality and Women's empowerment (GEWE) and Population Dynamics (PD) with humanitarian assistance integrated in all four outcomes. CP9 covers the 2017 – 2020 period with a budget of USD 52.6 and an independent evaluation of CP9 was conducted in 2019.

1.1 Purpose and Objectives of the Country Programme Evaluation

UNFPA Evaluation Policy and management guidelines require a final evaluation of the country program (CP) to be undertaken a year before the next CP is planned, hence this evaluation was carried out in the third year (2019) of the cycle to highlight lessons learned to contribute to the next Country Programme Document (CPD) development. The evaluation outcomes will be presented to the Executive Board together with the CPD outlining CP10. The evaluation followed UNFPA Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA," (2019 updated version); ensuring high quality evaluation with the highest level of objectivity, independence and impartiality.

The Country Programme Evaluation (CPE) serves three main purposes to support the country office achieve its intended results: (a) It is a means to demonstrate accountability to stakeholders on performance in achieving development results and on invested resources: (b) It supports evidence-based decision-making; and (c) It contributes important lessons learned to formulation of the next country programme. The evaluation aims to provide independent inputs to CP10 and the strategic direction of the continued role for UNFPA support to the Government in its commitments towards attaining the sustainable development goals (SDGs) as well as ICPD+ 25 and the post-MDG agenda.

This evaluation assessed CP9 performance; the factors that facilitated or constrained achievement, and documented the lessons learned from the past cooperation and UNFPA strategic positioning in the country to inform the formulation of CP10. The main audience and primary users of the evaluation are the decision makers and programme managers in UNFPA country office (CO), UNFPA Asia and the Pacific Regional Office (APRO) and UNFPA Headquarter divisions, and counterparts in the Government of Bangladesh (GoB). Additionally, other partners, donors (Sweden, Canada, Netherlands, UK Etc.), civil society and other UN agencies (e.g. WHO, UNICEF, UN Women, ILO and the RCO) are the intended audience.

Conducted by an independent evaluation team in accordance with UNFPA guidance on Country Programme Evaluations, ethical norms and UNEG standards, the evaluation is managed by the CO M&E team in close collaboration with APRO Regional M&E Adviser and with oversight from the Independent Evaluation Office of UNFPA in New York.

Specific Objectives

With the overall objective of creating a broadened evidence-base for the design of CP10, the specific objectives of the CPE are to:

a. provide an independent assessment of the relevance, effectiveness (progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme), efficiency, and sustainability of the approaches adopted by the current CP;

b. provide an assessment of the CO's strategic positioning within the development community and national partners, in view of its ability to respond to national needs while adding value to the country development results;

c. draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle (10th CP) 2021-2025, and

d. assess UNFPA's comparative advantage in the four programme areas in both development and humanitarian settings.

1.2 Scope of the evaluation

The scope is to cover CP9 implementation period (2017 to 2019) with initiatives[2] selected based on agreed criteria, under the four outcomes and seven outputs with several sub-outputs, implemented during CP9, including the humanitarian response. Besides the assessment of the intended effects of the programme, the CPE attempted to identify key unintended effects. To complement the assessment of the programme components, the evaluation team also assessed the managerial, operational (e.g. financial and administration) and monitoring and evaluation system of the CO.

1.3 Methodology and Process

Evaluation criteria and evaluation questions:

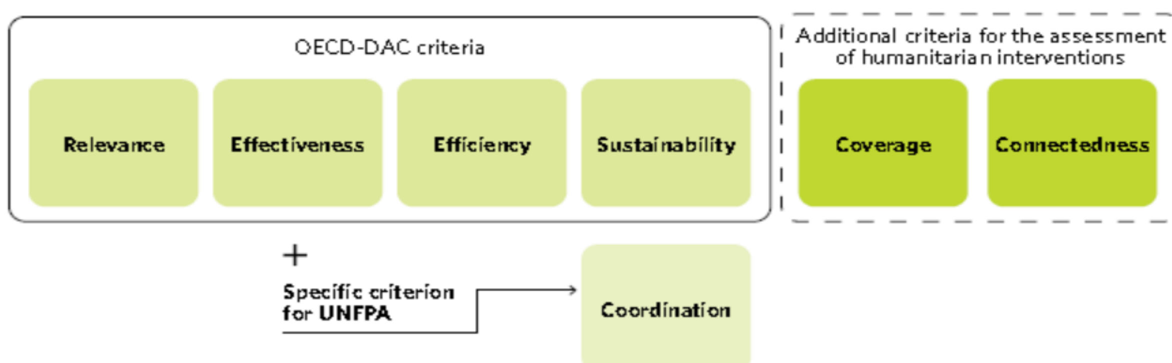
The evaluation focused on two key components. 1) The outcome areas Sexual and Reproductive Health and Rights (SRHR), Adolescent & Youth (AY), Gender Equality and Women's Empowerment (GEWE), and Population Dynamics (PD) using OECD/DAC evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability, in both development and humanitarian contexts. 2) Specific to UNFPA evaluation, Coordination which analyses UNFPA Strategic Positioning in the country with a focus on UNCT Coordination and UNFPA's comparative advantage in the development agenda within the development community and national partners in responding to national needs. Coordination measures to the extent to which UNFPA has been an active member of, and contributor to, the existing coordination mechanisms of the UNCT and as well as how it has positioned itself vis-à-vis the UNCT.

With the multiplication of humanitarian crises, more than ever before, the country offices are required to provide humanitarian assistance. In the assessment of humanitarian interventions; two additional evaluation criteria are considered, namely, coverage and connectedness. In this, the evaluators considered the ability of UNFPA to respond to humanitarian crises and the extent to which the country office has been able to apply a resilience approach by linking prevention, preparedness, response and

[2] TOR suggests all activities in 19 districts; this is not feasible in terms of the field work of the evaluation plan as time does not permit covering all districts. A non-probabilistic sample will be selected by consulting the CO staff.

early recovery with national capacity building. Specific attempt was made to see if gender aspects were included in the design and implementation of these different phases of humanitarian interventions.

Figure 1: Evaluation Criteria for the CPE



Source: Handbook UNFPA- CPE Evaluation Guidelines (2019 version)

For connectedness, evaluation looked at: (a) the establishment of linkages between the relief and the recovery phases; and (b) the extent to which local capacity has been supported and developed.

Upon desk review of key documents and CO programme staff's presentation of the detailed overview of the programme components and approaches supporting the method of programme implementation, the team prepared evaluation design matrices (Annex 4) that included eight evaluation questions, assumptions, indicators, data sources and data collection methods. Stakeholder map (Annex H) was used in identifying the sources for interviews, discussions, and feedback. The methods for data collection and analysis were determined by the type of evaluation questions formulated to test the assumptions. The following are the selected evaluation questions:

Evaluation Questions:
Relevance EQ 1: In what way(s) was the UNFPA country programme able to (i) address the various needs of the population, including vulnerable and marginalized groups, (ii) align with government priorities; and (iii) respond to changes in the national development and humanitarian contexts during its period of implementation? EQ2: To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country? **Effectiveness** EQ 3: To what extent have the expected outputs of the 9th country programme (CP9) been achieved in the development and humanitarian contexts? And to what extent have these outputs contributed to the achievements of the outcomes? **Efficiency** EQ 4: To what extent has UNFPA made good use of its human, financial and administrative resources, and used an appropriate combination of tools and to demonstrate accountability to stakeholders and pursue the achievement of the outcomes defined in the 9th country programme in a timely manner? **Sustainability** EQ5: In what ways has UNFPA been able to support implementing partners and beneficiaries in developing capacities and establishing mechanisms to address the challenges to ensure ownership and the durability of effects? **Coordination** EQ 6: To what extent did the UNFPA country office contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities) within the United Nations system? EQ7: To what extent has the CO established, maintained and leveraged different types of partnerships to utilize UNFPA's comparative strength to achieve the outputs and outcomes of CP9? **Coverage, Coherence, & Connectedness– Humanitarian Setting**

EQ 8: To what extent are UNFPA interventions and approaches to addressing SRHR, GBV and harmful practices in humanitarian settings in line with the principles of coverage, coherence and connectedness and in which ways have they been coordinated with other agencies and stakeholders?

1.3.1 Selection of the Sample

Employing purposive sampling method based on the knowledge of the programme, the evaluation team (ET), with input from CO, selected the sites for field visits for data collection (Ref table 2). The design of the evaluation and finalization of site selection were reviewed and approved by CO, APRO and ERG. The sites illustrate a mix of interventions (e.g. regular development programming, humanitarian response programming, work with vulnerable groups, etc.), type of implementing partners and targeted populations, the maturity of the interventions and the scalability and other specific coverage on gender, human rights approach and vulnerability to reflect different strategies that CO had followed in the implementation across the country's districts. Feasibility of covering these locations is based on the logistics given the geographic spread and the time available for the data collection and analyses.

CP9 covers 19 underserved districts out of 64 with SRHR component present in all 19 target districts, Gender component in five and Adolescent and Youth component in seven districts with many interventions national in scope, e.g., advocacy, contraceptive security and the SWAp, campaign on GBV, standardization of life skills education etc. Population and Development (P&D) interventions are mainly on policy and advocacy at national level with a strong capacity development component and "soft interventions" aiming that the entire country will benefit from UNFPA support. Under P&D, major focus of data collection is at the national level with the exception in humanitarian setting.

Upon document review and initial consultations with CO staff, evaluation team (ET) selected seven programme sites based on criteria below. The selection was a non -probabilistic sample based on knowledge and informed decisions.

Table 2: Selected Sites for Field Visits

District	Sub-District	Criteria (justification) for selection
Dhaka	City Corporation	A&Y and Gender intervention, and availability of all national stakeholders
Jamalpur (North)	Dewanganj, Sharishabari and District Hospital	- SRHR incl. FP, Gender and A&Y interventions - Disaster prone district – flood-prone; - High child marriage; GBV sub-cluster - Midwifery led care intervention with evidence based practice
Tangail		-Brothel (on the way to Jamalpur), marginalized group, SRHR and FP
Patuakhali (South)	Kalapara, Dashmina and District Hospital	- SRHR, Gender and A&Y interventions - Disaster prone district – flood and cyclone- prone - Midwifery led care intervention with evidence based practice
Moulvibazar (North east)	Sreemongal and District Hospital	-SRHR incl. FP of Marginalized population (Tea garden workers) -Fistula intervention. -More positive cases identified during cervical cancer screening (VIA) -Specific interventions for tea garden workers; -Additional HR (FP counselor)
Sunamganj (North east)	Jagannathpur, Derai and District Hospital	- SRHR incl. FP in least accessible area -Flood and landslide prone district -HR gaps -Only SRHR intervention; SRHR needs are among the highest
Cox's Bazaar (South)	Moheskhali, Uhkiya and district centre	-Humanitarian and development programme; Disaster prone, -HR gaps -Both Rohingya and host community are in Ukhiya and Teknaf Upazilas -Ukhiya is a strategic location to obtain services for the neighboring areas such as Teknaf Upazila --Some of the Upazilas are isolated and hard to reach (such as Moheskhali and Kutubdia); - SRHR incl. FP of, Gender and A&Y programmes

1.3.2 Data Sources, Collection and Analysis

Sources of data were both primary (mainly qualitative nature) and secondary, based on a mix of quantitative and qualitative data, derived from multiple sources. The evidence in this evaluation included data collected from the field, direct observations, structured and semi-structured interviews, key informant interviews(KII), informal group discussions, focus group discussions (FGD), and secondary sources such as desk review of documents. Desk review included CP-related documentation, relevant national policies, strategies and action plans, national statistics, review and evaluation reports, monitoring reports (quarterly reports, project-specific reports, annual reports, trip reports) submitted by IPs and UNFPA staff. A detailed list of documents reviewed is attached (Annex 3). The evaluation triangulated data sources, data types, and data collection methods. The triangulation of data collection minimized the weaknesses of one method, and was offset by the strengths of another, enhancing the validity of the data.

Country Office staff provided a list of stakeholders representing the national and local government, UN Agencies, donors, other development partners, and most importantly, the beneficiaries of the programme and civil society organizations (CSOs) which are very few. Upon extended consultations with the CO staff, evaluation team (ET) finalized the list of stakeholders for interviews based on the programme documents and interventions focusing on major categories of stakeholders distributed across the CP9 programme themes. Although this selection covered all four strategic outcome areas, it is not a representative sample. A purposive sample was selected to reflect the interventions and the participants involved.

The following table shows the rich mix of primary data sources. Validation was achieved through stakeholder meetings via debriefing meetings with UNFPA staff, ERG members and Implementing Partners at two different stages of the evaluation.

Table 3: List of Representing Institutions and Number of Stakeholders Met

Institution	Male	Female	Total
UNFPA CO including Cox's Bazar Sub-Office and Field Officers	24	18	42
Other UN Agencies (UNRCO, UNICEF, WHO, UN Women, UNHCR)	3	5	8
National Government Level (MoHA, MOWCA, GED, BBS, DIFE, MoLE, BD Police, DWA, National Legal Aid Services Organization, NCTB, DSHE, NSDAS, DYD	26	8	34
Parliamentarians	2	-	2
District Level (CS, Police, Courts, SCF Mentors, OCC)	23	16	39
Other development partners (SIDA, CIDA, WB, and Dhaka University)	7	3	10
Sub-district level (WHD, Police, Health complex midwives, OCC)	16	12	28
Ward level (Medical staff, CHW, NNPC, women beneficiaries, case workers/managers)	4	6	10
NGOs/CSOs (Shabolomby, Sushilan, Mukti, GUK, ASK, YPSA, Unnayan Shangstha), CWFD, Population Council, Plan International	34	21	55
Students (A&Y programme) – Generation Breakthrough Programme; Acceleration Action to End Child Marriage Programme	32	86	118
Beneficiaries of health facilities, WFS	13	46	59
Total (Approximate numbers)*(the list of names available in Annex 2)*	**184**	**221**	**405**

Data collection via individual face-to-face interviews, group interviews, and focus group discussions where feasible, adopted a participatory approach. Direct observation method was also used by participating in CP9 planned activities. The respondents (e.g., implementing partners, civil society, programme participants, donors etc.) were given the opportunity to discuss freely about the programme and to propose what works for them to make the programme better in their own context. Using Likert scale (with Strongly agree to Strongly Disagree options) an attitudinal survey was administered to UNFPA CO, Cox's Bazaar office, Field Staff, and a convenient sample of IPs to obtain their opinion on a variety of statements ranging from relevance, efficiency, and sustainability (N=47).

Data Quality: Data quality was maintained by triangulating the data sources and methods of collection and analyses. Validation of preliminary findings, by key stakeholders, enhanced quality of data collected ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings.

Data Analysis: Analysis of quantitative data was based on the availability of primary and secondary data, their quality, and comparability. Content analysis was employed to interpret qualitative data. Qualitative data, secondary quantitative data and other evaluation findings from existing reports were triangulated in making conclusions from the findings. Special consideration was made, where feasible, to include and reflect how boys, girls, men and women, and those belonging to marginalized groups (ethnic and indigenous populations, tea garden workers, sex workers, urban poor, etc.) were included in the CP9 programme design and implementation.

Retrospective and prospective analysis and the evaluation criteria: The evaluation team assessed the extent to which results have been sustainable, where expected results have already been generated, and examined the prospects for sustainability, i.e., the likelihood that the effects of UNFPA interventions will continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was mainly based on respondents' perceptions. The same was applied to effectiveness: evaluators assessed the extent to which the objectives have been achieved or likely to be achieved. Previous evaluation findings and programme documents, country office monitoring and performance data, and field observations were combined with interview data to substantiate ET findings. Relevance and Efficiency were assessed mainly by reviewing the related policy and strategy documents, financial documents and face-to-face interviews with relevant stakeholders.

1.3.3 Process Overview

The CPE process included five phases: a) Preparation, b) Design, c) Field visits, d) Reporting, and e) Management response, dissemination and follow up. ET's responsible areas were b, c, and d.

The preparatory phase was done by the country office and the evaluation team completed Design Phase which included desk review of key documents; stakeholder mapping; analysis of the programme intervention logic (TOC); finalization of the evaluation questions and development of data collection and analysis strategy and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and country office staff.

The Field Phase/ Data collection and Analysis Phase: After the design phase, the team undertook field visits based on the sample districts selected. At the national level, data were collected from lead ministries, departments, selected donors, UN agencies, UNFPA staff and other strategic partners. At the end of the field phase a debriefing on the preliminary results took place with CO staff and ERG members to validate the findings. At this stage, no concrete conclusions and recommendations were presented as it was too premature to make conclusions and recommendations.

Reporting Phase: The draft report was prepared and reviewed by the CO staff, the ERG, Regional Office M&E advisor, and the Evaluation Manager for quality assurance. During the second draft development process, relevant programme officers were given an opportunity to review and comment on the content prior to sharing the report with broader stakeholders. The second draft was presented to the national stakeholders and CO staff for further validation and finalization of the CPE report based on feedback from the reviewers. The Evaluation Team worked in close consultation with the country office programme staff in each of the phases and steps of the entire evaluation process.

Stakeholder Meeting

Validation mechanisms: Besides a systematic triangulation of data sources and data collection methods and tools, the CPE design and preliminary findings were validated via two workshops with ERG and UNFPA CO staff members. Another broader stakeholder workshop, with implementing partners, donors, UN agency staff, and other relevant stakeholders, was held to present the findings and recommendations of the evaluation.

Evaluation results dissemination plan: CPE findings and recommendations will inform the development of the CP10. The preparation of the management response and implementation of its actions and the dissemination of evaluation results will be the responsibility of the CO.

Ethics and maintaining the quality of evaluation*:* Several precautions were taken to ensure the protection of respondents' rights. Informed consent was sought before all interviews were made and the data collected were confidentially kept, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation. Respondents were explained about their right to provide the feedback – this included individual, group discussions, and FGD as well.

The evaluation team (ET) made every effort to ensure the credibility of data by triangulating the sources of data. The ET followed the UNEG guidelines and standards on "Integrating Human Rights and Gender Equality in Evaluation" as well as UNFPA's Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA" (updated version) in carrying out the CPE to ensure quality and gender integration.

Evaluability Assessment, Limitations and Risks: While the fully developed theory of change for each of the programme outcome was helpful in understanding the links from outputs to outcomes the overall TOC for the entire CP9 programme as such was not present and the critical assumptions and limitations were not included in the CP9 programme logic (proposed theory of change), though the CO faced major humanitarian situations and setbacks in government policies with regard to FP interventions.

Development of a comprehensive TOC was not within the capacity of the team given the short time frame. However, the evaluation team went over the individual TOCs and checked where the duplications can occur. SRHR has several components that should have been linked to the outcome logically, however only separate TOCs were available, not a comprehensive one for the overall SRHR outcome. Though an effects diagram would have been useful to understand the overall CP9 strategy, the linkages for the outputs were clear and the team was able to discuss with programme officers and understand the logic based on the current TOC.

Establishing a representative sample for data collection was a constraint in hard to reach geographically remote areas, however, with a thorough understanding of the programme interventions purposive samples were selected to reflect the interventions to avoid or minimize the selection bias. During the field visits, team observed some centers with less service facilities that were hard to reach as well as centers that were easier to access. This provided the team with a balanced picture. However, all programme sites visited by the team in the field were selected by the implementing partners or the UNFPA field officers and there may have been a selection bias. This limitation was mitigated by triangulating the data/findings by documented results of previous independent evaluations, direct observations, interview of stakeholders (policy makers, service providers, and intended service receivers) at multiple levels.

The results frameworks of CP9 have changed in response to keeping in line with two Strategic Plans (SP 2014-2017 and SP 2018-2021) within one programme cycle. CP9 programme period is four years, however due to humanitarian situation and the delays in approval processes the actual implementation has been around one and a half years at the time of this evaluation. Team took note of the less than full period for the programme interventions to fully realize the results as some interventions may not have had time to mature to achieve results. Issues with differences in languages spoken across the districts were managed by engaging suitable translators native to those geographic regions.

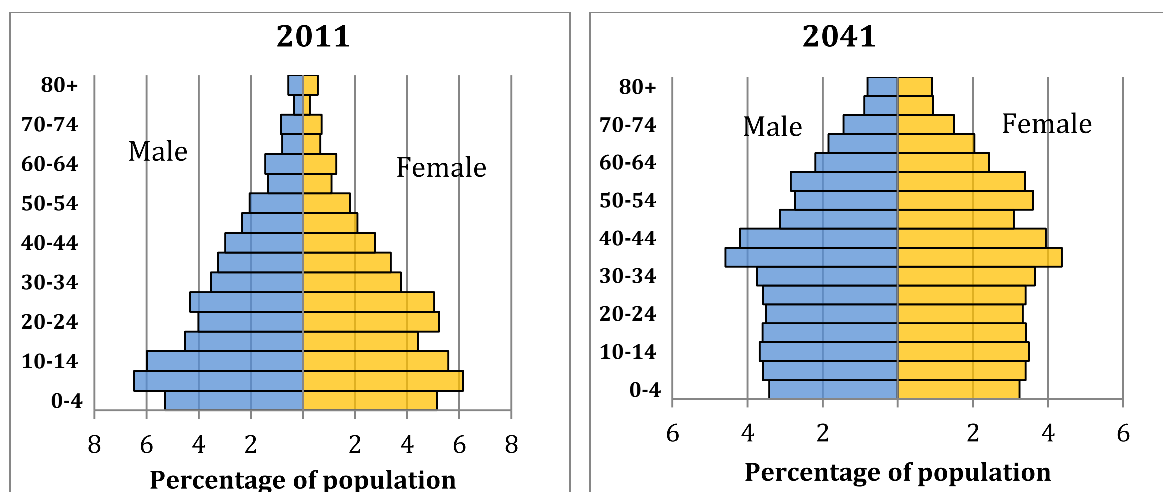
Data Gaps: While current administrative- and survey-based information systems of the country provide sex- and age-disaggregated data, there is limited data available to identify the inequalities across various groups such as the indigenous peoples, people with disabilities, poorest of the poor, etc. across the programme. To mitigate this program specific survey data were used to interpret the findings.

Chapter 2: Country Context

Bangladesh, in 2018, has fulfilled the eligibility criteria set by the World Bank to be recognized as a developing country, crossing over from the list of least developed countries (LDCs). With a population of 168 million and an annual growth rate of 1.1%, country's population density is 1,103 persons per sq.km.[3] The country is in the third stage of the demographic transition model - low birth rate and low death rate - made possible by successful efforts in family planning, advancing educational attainment and gender equality, and reducing infant mortality and poverty.

A significant progress has been observed in achieving many of the goals of the ICPD POA and MDGs. GDP Annual Growth Rate averaged 5.76 % from 1994 until 2017, reaching an all-time high of 7.30% in 2017 and a record low of 4.08% in 1994. The per capita income has increased to $1,751 in FY2017-18 from $1,610 in the previous fiscal year (Bangladesh Bureau of Statistics -BBS). The extreme poverty rate was 41.1% in 1991, and declined to 12.9% in 2016.[4] Progress has been uneven, and socio-economic, geographical and gender inequalities have been widened with inequalities in access to quality reproductive health services and disparities in health outcomes and gender inequalities. Following a successful Family Planning programme, the total fertility rate (TFR) fell from 3.3 in 1999-2000 to 2.3 in 2017.[5] UNFPA-commissioned *Demographic Impact Study 2015* reports that the country is adding 2 million people to its population every year, and it will reach 200 million by 2041 based on the medium projection (TFR=1.9). The country is now going through a 'demographic window of opportunity' with more than 30% of its population being young, 10-24 years of age. As seen in figure2,[6] two shifts are also taking place in the country's demography: Ageing population is increasing while working age population is also increasing.

Figure 2: Population Pyramids (2011 and 2041)



[3]SWOP, 2019, https://www.unfpa.org/data/world-population/BD
[4]Voluntary National Review (VNR) 2017, Government of Bangladesh.
[5]BDHS, 2017 (according to SWOP2019, 2.0)
[6]The impact of demographic transition on Socio Economic Development in Bangladesh: Future Prospects and Implications for Public Policy, 2015

Bangladesh is also one of the most disaster prone countries in the world. The country is exposed to high vulnerability to hazards, calamities related to climate change and natural disasters. Since 2017 Bangladesh has been the host country for a substantive Rohingya refugee crisis. While this is one of the largest in the world, as of January 2019, over 900,000 stateless Rohingya refugees reside in Ukhiya and Teknaf Upazilas.

2.1 Development Challenges and National Strategies

Bangladesh CP9 consists of four strategic outcomes in the areas of: Sexual and Reproductive Health Rights, Adolescents and Youth, Gender Equality and Women's Empowerment, and Population Dynamics. Key areas under SRHR are maternal and newborn health, family planning, cervical cancer, fistula, integrated SRH services including HIV and AIDS and Adolescent Reproductive Health, including in humanitarian settings. Following section discusses the development challenges and national strategies related to these outcome areas with a focus on the areas related to the UNFPA mandate.

2.1.1 Development Challenges: Sexual and Reproductive Health and Rights (SRHR)

Bangladesh has made a tremendous improvement in **maternal and newborn health** over the past 40 years, with the Maternal Mortality Ratio (MMR) reduced from 648 in 1981 to 196 in 2015[7], though has plateaued over the last decade. The latest BDHS shows significant increases in facility births without decreased maternal mortality, which highlights the issue of quality of care, most notably that there are big gaps in treatment of the leading causes of maternal deaths, particularly eclampsia, postpartum hemorrhage (PPH) and abortion. There is a considerable way to go in order to reach the SRHR related targets committed to in relation to the 2030 Agenda and the Sustainable Development Goals. In order to ensure safe delivery and respectful care for all pregnant women and girls, the management of complications in delivery and the availability of and access to Emergency Obstetric and EmONC[8]) services, are critically important as they can save women's lives as well as the lives of new bornes.

The **contraceptive prevalence rate** (CPR) increased substantially in the period 1994 to 2004, when it increased from 45 to 58 percent, while the increase slowed down in the next decade from 2004 to 2014 when usage increased by 4 percentage points. More recently, the CPR has plateaued with only a small increase from 61.2 to 62.4 percent between 2011 and 2014.[9] The use of modern family planning methods constitutes 52 percent with the use of the pill by far the most widely used method (27 percent), The use of contraceptives is more limited for married adolescents, where CPR reaches 52 percent, while unmet need for family planning amounts to 17 percent. Recent exposure to family planning messages has declined over time. While in 2004, 44 percent of currently married women reported having seen or heard family planning messages in the last month, this was only 30 percent in 2014.[10]

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[7]Government of the People's Republic of Bangladesh, Eradicating poverty and promoting prosperity in a changing world, voluntary National Review (VNR), 2017, Dhaka, June 2017; BMMS.

[8] EmONC is meant to include BEmONC and CEmONC

[9]National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

[10]National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and

In terms of **reproductive health morbidities**, focus has been on cervical cancer and obstetric fistula. **Cervical Cancer** accounts for about one in four cancer cases among women in Bangladesh. Awareness about the disease as well as options for screening for the disease is low. There is a new call for elimination of cervical cancer.[11] **Obstetric Fistula is** one of the most severe and tragic childbirth injuries in Bangladesh, which affects an estimated 20,000 women across the country. Obstetric fistula is more prevalent in rural areas with poverty and limited access to health care.

National Strategies SRHR:

Government Seventh Five Year Plan includes fiscal years 2016 – 2020. Sexual and reproductive health is included under the health, nutrition and population development part of the plan. The role of the Ministry of Health and Family Welfare (MOHFW) is reaffirmed in terms of policy management and coordination for an effective and efficient health system with contributions from public, non-public and private sectors and health NGOs. **Health, Population and Nutrition Sector Development Programme:** Maternal health is part of the Health Population and Nutrition Sector Development Program (HPNSDP) and includes expanding the access and quality of MNCH services and strengthening of various family planning interventions to attain replacement level fertility. **Eclampsia and Postpartum Haemorrhage (PPH) Action Plan** of 2018, identifies postpartum haemorrhage and eclampsia at the two main causes for maternal deaths in Bangladesh and provides measures to address both these causes. The aim of the plan is to accelerate the reduction of maternal mortality and morbidity caused by eclampsia and PPH by 2022 through improved access to evidence-based maternal health care and emergency obstetric care.

National Midwifery Policy / National Policy Guideline for Midwives focuses on the quality of maternal and new-born care in order to further reduce the maternal and new-born mortality in Bangladesh. The policy aims to create a positive environment for midwifery governance and practice and to promote midwifery education and accreditation and quality of midwifery care, in a way in which it becomes integrated with other care in hospitals and communities. The policy promotes a competent midwifery workforce, capable to lead reproductive, pregnancy, birth and new-born care in line with international standards and includes details on the development of midwifery education, training, accreditation and services.[12]

Fistula strategy includes the adoption of a goal of zero incidence of obstetric fistula, to treat all genital fistula on a road map to a fistula-free Bangladesh by 2030. The strategy focuses on six key strategic directions, including prevention, awareness, treatment, quality of surgery, rehabilitation/reintegration and evidence generation through research.

The Cervical cancer strategy provides broad guidelines for the strengthening of the National Cervical Cancer Control Programme through the introduction of vaccination of adolescent girls against the Human Papillomavirus using the expanded programme on immunization and the implementation of population based cervical cancer screening and treatment through the public health delivery system.

Associates, and ICF International.

[11] In May, 2018, at the World Health Assembly, the Director-General of WHO made a global call for action towards the elimination of cervical cancer as a public health problem.

[12] DGl of Nursing and Midwifery, Ministry of Health and Family Welfare, National Policy Guideline for Midwives, 2018.

The National Adolescent Health Strategy has identified four priority thematic areas of intervention: adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition and mental health of adolescents. Social and behavioural change communication and health systems strengthening are included as cross-cutting issues, which are deemed required for the effective implementation of the strategy.

2.1.2. Development Challenges: Adolescents & Youth

According to the definition of GoB, approximately 20% percent adolescents (10-19 years) and 30% of the total population are youth (18 – 35 years) (NYP 2017)[13]. With a large population of young people (adolescents and youth), a demographic transition is underway. Reaping the **demographic dividend** is closely linked to the development and empowerment of young girls and boys.

More than half (59%, BDHS 2014) of women aged between 18 – 24 years have married before the age of 18 years, therefore, falling at risk of early pregnancy and other health risks. **Child marriage** also hinders the education and any future prospect of the young girls. Risk of unwanted pregnancies and unsafe abortion in adolescent's increase, when they become sexually active without knowledge of contraceptives, before or after marriage. Against this backdrop, access to reliable **ASRHR information and services** is both a priority and a challenge.

National Strategies**: **Policy Environment for Progress toward Adolescent & Youth:

UNFPA has supported the Ministry of Women's and Child Affairs (MoWCA) to formulate the national plan of action to end child marriage, and worked with DYD to develop the Action Plan for National Youth Policy 2017 which will contribute towards developing the capacity to deliver gender-responsive and age-sensitive SRH information and services, including FP, for in-school and out-of-school adolescents and youth. UNFPA has advocated with GoB for the development and implementation of national policy instruments NPA-ECM, National Adolescent Health Strategy, and NAP- GBV, VAW and has a specific focus on improving the quality and accessibility of services for maternal health, gender based violence and family planning. It did this through local level consultations, training and dialogues with the stakeholders, and consultations with adolescent girls and boys on the ground. The National Adolescent Health Strategy 2017-2030 was developed to address the overall health needs of adolescents by taking a broad and holistic understanding of the concept of health. It also fills a gap where adolescent health issues were not addressed comprehensively in other policy documents.

2.1.3. Development Challenges: Gender Equality and Women's Empowerment (GEWE)

Out of a total population of 168 million[14] almost half are women. However they are not free from various social, political, economic and cultural barriers. While positive changes in women's lives in the past few years have been observed, progress has been uneven and inequalities in access to quality

[13] About 50 million (30%) young people (10-24 year olds), 20% adolescents (10-19 years), 20% youth (15-24 years), 30% youth (as defined in Bangladesh– 18-35 years), 50% young people (as defined in Bangladesh – 10-35 years) Ref: Bangladesh National Youth Policy 2017, UNFPA Independent Evaluation Report 2016, The baseline survey of the Generation Breakthrough project, conducted by Human Development Research Centre.

[14] SWOP, 2019, https://www.unfpa.org/data/world-population/BD

reproductive health services, disparities in health outcomes and gender inequalities in many areas still persist. The second round nationally representative survey on **violence against women** (BBS, VAW Survey, 2015)[15] revealed that about 73% of once-married women in Bangladesh have experienced some form of partner violence in their life-time and more than half (54.7%) have experienced violence in the last 12 months prior to the survey. The challenges recorded in this survey were: a) The prevalence of physical or sexual violence among ever-married women was by non- partner is 28.2%, b) Non-partner physical or sexual violence among women who have never been married is 35.3%, c) 41.3% once-married women know where they can report partner violence. Only 2.6% women took any legal action for partner physical or sexual violence and only 2.4 % know about the government help line (109). Fear from husband and concern of harming social prestige prevents them from reporting or seeking services.

National Strategies**: **Policy Environment for Progress toward Gender Equality

A National Action Plan to Prevent Violence Against Women (2013 to 2025, revised version is 2018-2030) have been launched and disseminated. UNFPA is supporting MOWCA to incorporate a costed annualized results framework to operationalize the National Action Plan; The Protocol on Health Sector Response to GBV for Health Care Providers is approved by MoHFW and rolled out; For the first time UNCT submitted UPR report [3rd cycle] where UNFPA took the lead and successfully incorporated GBV and SRHR issues; MoLE has developed (with UNFPA's support) and approved GBV strategy for the ministry and its departments. The government adhered to the UN Declaration of SDGs[16] where Goal Five explicitly states that women's full and effective participation and equal opportunities for leadership at all levels of decision-making at political, economic and public life should be ensured.

2.1.4. Development Challenges: Population and Development

Population Momentum: Despite fertility rates continue to decrease, population grows in absolute terms adding 2 million people to its population every year, and will reach 200 million by 2041 based on the medium projection (TFR=1.9), and by 2031 if TFR stayed at 2.3.[17] This momentum will have an impact on the country's development depending on the age structure, the most dramatic one being the increase in the elderly population relative to the number of working age persons.

Youth Bulge - Reaping the benefits of Demographic Dividend: With low birth rates and low death rates, the country experiences a demographic transition resulting in a youth bulge that offers a window of opportunity for the economic development of the country. The main challenge is how to take advantage of this youth bulge rather than trapping the next generation of citizens in poverty.

Ageing: Two shifts are taking place in the country's demography: while population ageing is increasing (8% in BBS, SVRS 2018), the working aged population is also increasing (62.7% in SVRS 2018). While Ageing is inevitably happening, the challenge for Bangladesh is not to "grow old before it gets rich."

Disability: *Persons with Disabilities (PWDs)*: It is estimated that approximately 9 percent of the total population, including 3 out of all households have a member with a disability. Disability on this scale represents not only a major health issue, but is also a prime cause of poverty and underdevelopment.

[15] Bangladesh Bureau of Statistics, Violence Against Women Survey, 2015
[16] UN, The 2030 Agenda for Sustainable Development, 2015 "Transforming Our World: the 2030 Agenda for SDGs."
[17] The impact of demographic transition on Socio Economic Development in Bangladesh: Future Prospects and Implications for Public Policy, 2015

Migration and urbanization: There has also been unprecedented urbanization as a result of combination of natural population increase, rural-urban migration and reclassification. Urban population is increasing and services to meet the needs are not simultaneously increasing. There is a proliferation of slums and squatter settlements and feminization of migration.

Regional Differences: The fertility situation is characterized by wide differentials between groups (i.e. the wealthiest and most educated women having sub-replacement fertility and the poorest and least educated women having the highest fertility) as well as wide regional differences with Chittagong Division in the East has higher fertility than Khulna in the West. Rural fertility is also observed to be higher than urban.[18]

Population Data and Research*:* Generation of age-sex disaggregated quality data and their timely release, limited access to public data, lack of capacity of national organizations on data collection, analyses and report writing, lack of synergies in approaches and methodologies of different agencies (need for data harmonization) and limited independence of National Statistical Organizations (NSO) are identified development challenges. The Bangladesh Bureau of Statistics (BBS) as an NSO has been engaged in collecting, collating and disseminating statistics on a wide range of economic, social, demographic and environmental variables.

Population & Development: National Strategies: The population policy, developed and approved formally in 2004, outlines that population control and family planning activities as integral elements of social reform and national development with a view to reducing family size to ensure sound maternal and child health, family welfare and higher standard of living. *Strategy for the population sub-sector:* Given the current scenario and projections of population growth, this strategy for subsector of HNP is particularly important for future development and as such, the Government has outlined a strategy to reduce the fertility rate and to create an environment where the citizens of Bangladesh will be aware and actively involved in checking population growth.

Influx of Rohingya population (Humanitarian Response: Between August 2017 and then end of 2019 an estimated 900,000 Rohingya refugees have fled into Bangladesh. In keeping with its national policies, the GoB refers to them "Forcibly Displaced Myanmar Nationals." They have been accommodated in large camps, in which women and girls experience high level of risks and violence, including sexual violence and exploitation.

Humanitarian Situation and natural disasters: Bangladesh is vulnerable to natural disasters further exacerbated by climate change. The Inform Risk Index 2019 rates the country as high risk (risk scale: 6.0) among 191 countries. The frequency of cyclones also has increased. In addition, five geological fault lines run through the country, exposing it to highly vulnerable of a major quake. If a massive earthquake with 7 or greater magnitude occurred in this country will led a major human tragedy due to the faulty structures of many buildings and a lack of proper awareness.

[18]ibid

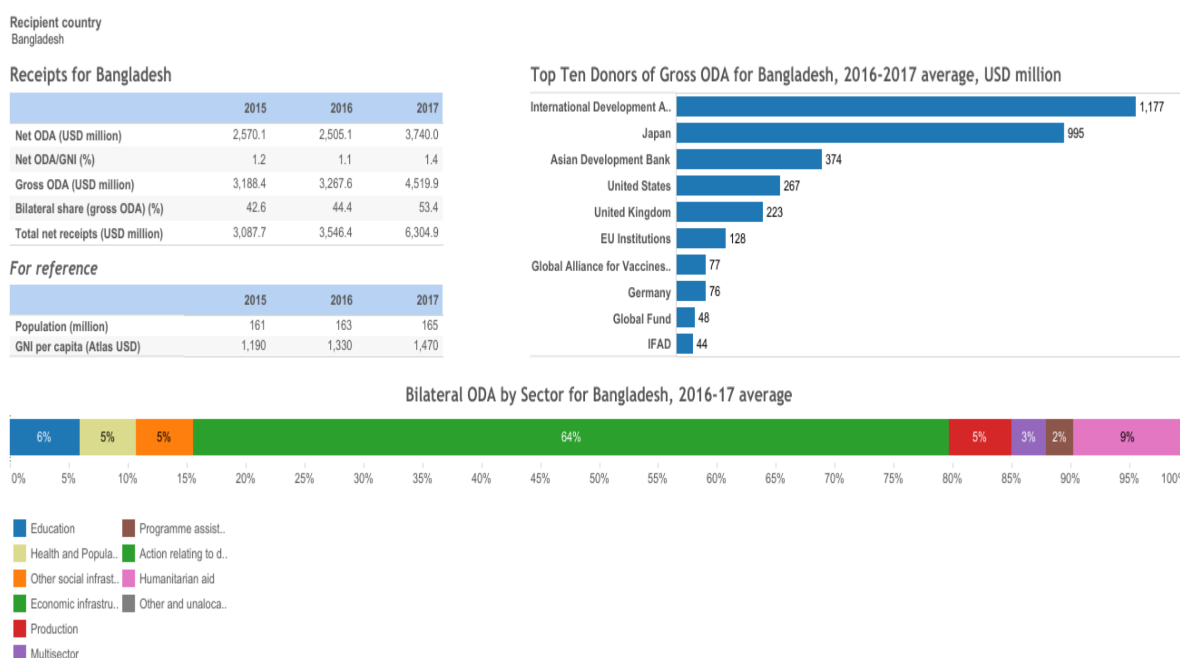
Key legal frameworks in Disaster management are: a) Disaster Management Act 2012; Disaster Management Policy 2015; Disaster Management Rule (DM Committee and its roles & responsibilities); Standing Orders on Disaster (SOD); National Plan for Disaster Management 2016- 2020. **Disaster**

Management (DM) Policy that has recently been approved by the Government of Bangladesh emphasizes on Disaster Risk Reduction (DRR) to a great extent and puts importance on a dedicated fund for DM. Overall, it is expected that the policy will be an effective instrument to make DM efficient in Bangladesh. The humanitarian assistance and risk reduction activities put much emphasis on gender responsive and disability inclusion programme.

2.2 The role of external assistance

Bangladesh is among the top ten recipients of Gross Official Development Assistance (ODA), with International Development Assistance and Japan being the highest contributors. The total ODA for the period 2015 to 2017 is given below in Figure 3 and in the same figure, top ten donors of gross ODA for the country 2016-2017 average and bilateral ODA by sector are also shown. In 2017, Bangladesh received USD 3740 million (8% of total disbursement) and was one of the top recipient of ODA in Asia[19]. ODA support to development planning and implementation in Bangladesh is significant and the task of coordination with the development partners and UN system is assigned to the Economic Relations Division (ERD).

Figure 3: Gross ODA 2016-2017 average, US$ Million



Recipient country
Bangladesh

Receipts for Bangladesh

	2015	2016	2017
Net ODA (USD million)	2,570.1	2,505.1	3,740.0
Net ODA/GNI (%)	1.2	1.1	1.4
Gross ODA (USD million)	3,188.4	3,267.6	4,519.9
Bilateral share (gross ODA) (%)	42.6	44.4	53.4
Total net receipts (USD million)	3,087.7	3,546.4	6,304.9

For reference

	2015	2016	2017
Population (million)	161	163	165
GNI per capita (Atlas USD)	1,190	1,330	1,470

[19] Development Aid at a glance statistics by Regions (for Asia) 2019 Edition.

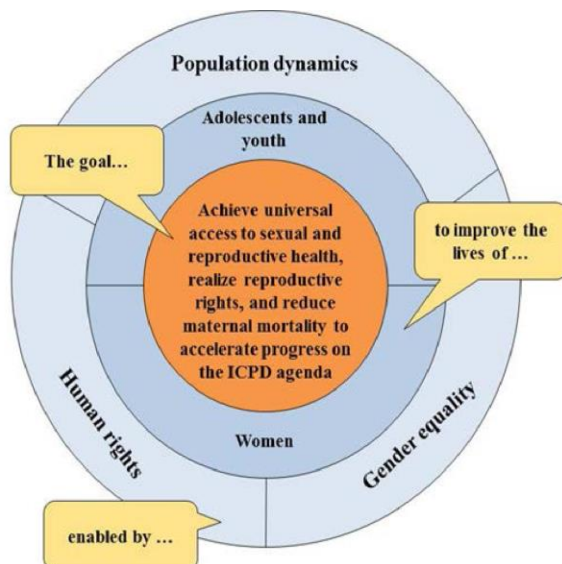
Chapter 3: UNFPA Response and Programme Strategies

3.1 UNFPA Strategic Response

UNFPA continues to closely work with the Government of Bangladesh and other national implementing partners supporting Government development priorities. While supporting to further the (ICPD) agenda, and the attainment of SDGs, UNFPA CP9 (2017-2020) has been developed taking into account national development policies, the goals and objectives on ICPD and its reviews, SDGs and UNFPA Strategic Plans. The UNFPA Strategic Plan 2018-2021 is aligned with the 2030 Agenda and its 17 Sustainable Development Goals. It also intends to respond to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015-2030. The country programme is synchronized with the United Nations Development Assistance Framework (UNDAF) for 2017 to 2020.

Originally, the Strategic Plan 2014-2017 (SP) covered the first year of CP (2017) with the rest of the CP keeping in line with SP 2018-2021 and reaffirmed the strategic direction represented by the "bullseye." UNFPA works around three transformative and people-centred results in the period leading up to 2030: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. This is planned to be implemented through: UNFPA "bull's eye" as shown below, for three consecutive strategic plan cycles. The implementation process will be enabled by evidence and population expertise, with a special focus on empowerment of women and young people, especially adolescent girls, both in humanitarian and development settings.

Figure 4: Strategic Direction of UNFPA, The "Bullseye"



The bull's eye, the overarching goal to achieve universal access to sexual and reproductive health and reproductive rights (SRHR), has brought clarity and focus to the work of UNFPA, and continues to be relevant in the current development era. SRHR rights are essential for advancing the Sustainable Development Goals, in all UNFPA contexts of operation. UNFPA has taken steps to integrate the theory of change, the modes of engagement and the integrated results and resources framework[20].

UNFPA will use its strategic plan to mobilize and align its institutional strategies to the 2030 Agenda, and, throughout the period of its three strategic plans, will monitor the 17 UNFPA-prioritized Sustainable Development Goal indicators. To achieve these transformative results, the strategic plan emphasizes the need for strengthened partnerships and innovation.

[20] SP 2018-2021

While SP 2014-2017 covered the transition from MDGs to SDGs, SP 2018-2021 is the first cycle of the three SPs leading to 2030 where the achievement of the "three zeros[21]" (transformative results) are planned.

3.2 UNFPA Response through the Country Programme

The following sections detail the previous country cycle and the current country programme.

3.2.1 Brief description of the UNFPA previous cycle strategy and achievements

UNFPA implemented its 8th programme of assistance from 2011 to 2016 during the SP strategy 2011 – 2014 and 2014-2017. CP8 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.

The interventions under the area of SRHR contributed to improved quality and accessibility of services for maternal health and family planning. Demand for these services had been, however, challenged by insufficient awareness among target groups, crowded or underdeveloped facilities, shortages of staff and socio-cultural barriers. The sustainability of results had been threatened by over-reliance of most interventions on external resources and the absence of exit strategies. Population and development had contributed to the strengthening of national capacities, specifically Bangladesh Bureau of Statistics (BBS) and Dhaka University to collect and analyse population data and the production of traditional census reports as well as of secondary analysis of 2011 census data. It had also promoted the use of up-to-date data collection and validation techniques by BBS. While UNFPA's contribution to the integration of population and gender equality concerns into national and sectorial plans and policies had been remarkable, the 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. Eliminating gender-based violence and advocacy against child marriage in targeted districts and municipalities had been the focus. Sustainability of results is limited by the lack of a comprehensive gender equality strategy.

UNFPA had not achieved timely disbursement of funds during the eighth country programme due to delayed approval of TAPP causing delayed implementation of some interventions. Serious human resource shortages in the country office had affected the achievement of several planned interventions, but effective action had been taken by the country office to increase staffing capacity and to accelerate the implementation of interventions. UNFPA had contributed effectively to good coordination and complementarity among the UN country team, particularly in strengthening advocacy against child marriage with other UN agencies and development actors and GBViE through national level GBV cluster.

3.2.2 Current UNFPA country programme

UNFPA 9th Country Programme of Support to Bangladesh: UNFPA has been working in partnership with the Government of the People's Republic of Bangladesh since 1974 through technical advisory

[21]Three zeros are to: (a) end the unmet need for family planning; (b) end preventable maternal deaths; and (c) end gender-based violence and harmful practices, including child marriage.

services and financial support completing eight country programme cycles. CP9 is linked to UNDAF Action Plan (2017-2020) and contributes to all three UNDAF Outcomes (Outcome 1: All people have equal rights, access and opportunities; Outcome; 2: Sustainable and resilient environment; and Outcome 3: Inclusive and shared economic growth).

Contributing to effective implementation of international instruments and commitments in Bangladesh, the strategic priority areas of the programme aligns with the 2030 Agenda and the Sustainable Development Goals. At the same time, it seeks to address the ICPD unfinished agenda and is guided by CEDAW, the Convention on the Rights of the Child, the Beijing Platform for Action, the Declaration on the Elimination of Violence against Women, the Government's five-year plan, 2016-2020, the plan of action of the National Women's Advancement Policy 2011, Family Planning 2020, UNDAF 2017-2020 and is directly contributing to the achievement of results under the national priorities on education, health, gender and equality of the 7th Five Year Plan of the GoB, as stated in the following programme outcomes:

CP9 Outcomes
Outcome 1: Sexual and reproductive health and rights-Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access. **Outcome 2: Adolescents and youth -**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. **Outcome 3: Gender equality and women's empowerment -** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. **Outcome 4: Population dynamics -** Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

The programme underscores the spirit of reaching those most left behind, including migrants, refugees, ethnic, religious and other minorities, tea garden workers, adolescent girls, and people living with or at higher risk of HIV. A careful geographic mapping exercise was conducted to select key target districts for its downstream implementation work where a large proportion of vulnerable population groups reside; while focusing on upstream advocacy for transformative policy and budgeting. Gender equality, empowerment of women and girls, and reproductive rights advancement in development and humanitarian settings are all central to the UNFPA mandate and are mainstreamed into all aspects of its work. Gender equality is an outcome area of the organisation's strategic plans and is mainstreamed across the other outcomes.

The results and resource framework (RRF) of the 9th CP clearly identified the outcomes and outputs with relevant indicators and resource requirements. The 9th CP set the target of a total of US$ 52.6 million (US$ 26.3 million from the Regular Resources and US$ 26.3 million to be mobilized from Other Resources) over the 4 years of 2017-2020. Although there is a significant decrease of UNFPA's regular resources in the past 3 years, UNFPA has been able to mobilize more resources from local development partners that has exceeded the 52.6 million USD committed in Country Programme Document (CPD).

The Country Programme Action Plan (CPAP) 2017-2020, developed based on the programme vision as stated in the ninth CPD and in close consultation with key stakeholders, is an operation plan which will guide UNFPA and Implementing Partners (IPs) in programme planning, implementation, monitoring, reporting and resource mobilization processes

CP9 implementation currently in its third year of its 4-year cycle, and suffered from a slow start in the first year (2017) and second year for some Government IPs mainly due to the delay of Technical Assistance Project Proposal (TAPP) approval process (except for Health sector). While this approval from GoB was necessary to initiate a UNFPA-supported projects some interventions had to wait till the latter part of 2017 for a smoother implementation until necessary agreements were signed with the IPs. In addition, humanitarian response to several emergencies in 2017, including cyclone Mora, flood in northern districts of Bangladesh, landslide in Chittagong Hill Track areas, and the Rohingya refugee response, created some delays in implementing the 9th CP. UNFPA's response to Rohingya refugee response is continuing up to date, with host communities are being targeted for response and recovery in addition to refugees.

During the last two years of CP9, it has focused mainly on strengthening technical and institutional capacities of government counterparts. Capacity development activities have been promoted, including development of national guidelines, strategies, protocols and training materials, conducting training and orientations in relevant reproductive health, population and development and gender issues; supporting knowledge translation, and implementation of evidence-based high quality sexual reproductive care, life skills education and adolescent friendly services, and Gender-based Violence (GBV). In view of the above circumstances and also due to the purposive sampling of the field sites, the team could not cover all the programmes enlisted by the UNFPA.

The Programme (CP9): Theory of change (TOC) of the four outcomes is in Annex F which shows the programme interventions under the four strategic outcome areas. SRHR programme has three outputs and multiple sub-outputs and they are illustrated in the annex F-1 of this report.

Geographical coverage of CP9 Interventions: UNFPA assistance is extended to 19 underserved districts out of 64 districts in Bangladesh. While P&D operates at the national level, SRHR component is present in all 19 target districts with Gender component in five districts and Adolescent and Youth component in seven districts. There have been many interventions which are national in scope, e.g., advocacy, contraceptive security and the SWAp, campaign on GBV, standardization of life skills education etc. The district level programme interventions are being coordinated through the 11 district offices; UNFPA has introduced local level planning as well to promote national ownership and capacity development for planning and budgeting and monitoring at the local level.

The programme is nationally executed (NEX) with the Government, in close partnership with other UN agencies and non-government organizations (NGOs). 14 government IPs ministries, departments, and academic institutions and twenty five NGOs are engaged to achieve the above outputs contributing to the outcomes. The Economic Relations Division (ERD) of the Ministry of Finance is the overall coordinating agency for the UN agencies, including UNFPA's CP9.

UNFPA assistance includes three joint programmes (two with UNICEF and one with WHO) for improving SRHR including maternal and newborn health (funded by GAC) implemented in five target districts, Global Programme to Accelerate Action to End Child Marriage in two target districts, and Better Health in Bangladesh: Technical Assistance for Strengthening Health Systems (funded by DFID) in 20 districts including nine CP9 target districts. In addition, CO has four multi-bilateral projects implemented with government and non-government IPs (Generation Breakthrough funded by the Kingdom of the Netherlands, strengthening Midwifery-led Continuum of Care in Bangladesh (2017-2021), funded by SIDA, ASTHA: strengthening Access to Multi-sectoral Public Services for GBV Survivors in Bangladesh (November 2017-December 2021) funded by the Kingdom of the Netherland, and strengthening SRHR and GBV Services in Cox's Bazar (March 2019- March 2021), funded by DFAT). All these projects have contributed to the country programme.

3.2.3 The Country Programme Financial Structure

UNFPA country expenditure has been linked to work plan activities through the Global Programming System (GPS). UNFPA remains vulnerable to fluctuations in the global financial landscape as it has limited ability to predict funds accurately and secure them annually, as few top donors commit to multi-year funding. The biggest challenge has been to manage core operations functions given the significant decline in core funds and an increasing number of agreements covering non-core funds. The following table shows the indicative allocation for CP9.

Table 4: Overview of the budget (Allocation indicative) for the programmatic areas of CP9-Bangladesh: 2017-2020 (USD Million)

Strategic plan outcome area	Regular Resources	Other Resources	Total
Outcome 1: Sexual & Rep. Health	9.4	18.8	28.2
Outcome 2: Adolescent and Youth	4.8	5.0	9.8
Outcome 3: gender equality & women's empowerment	7.6	0.5	8.1
Outcome 4: Population Dynamics	2.5	2.0	4.5
Programme coordination & assistance (PCA)	2.0	-	2.0
Total	26.3	26.3	52.6

Humanitarian programme resource allocations are within SRHR and Gender thematic areas.
Source: UNFPA Country Office

Table 5: Overview of the Budget and Expenditures by Year, For the period: January 2017 to 30 June 2019 (All figures are in US Dollars)

	2017		2018		2019		Total	
Sources of Fund	Budget	Expenditures	Budget	Expenditures	Budget	Expenditures	Budget	Expenditures
Regular Resources (RR)	5,409,307	5,170,460	6,199,386	6,082,893	5,547,188	2,803,800	17,155,882	14,057,153
Other Resources (OR)	11,938,992	9,691,347	23,775,656	21,152,670	24,111,689	12,828,669	59,826,337	43,672,685
	17,348,300	**14,861,807**	**29,975,042**	**27,235,563**	**29,658,877**	**15,632,468**	**76,982,219**	**57,729,839**

Source: UNFPA Country Office. Implementation Rate (up to June 2019 0nly) 82% RR , 73% OR, 75% total (CP9 is until 2020)

Table 6: Overview of the budget expenditure (in USD)by mode of engagement (Jan' 2017-June 2019)

	Expenditure			
Mode of Engagement	2017	2018	2019	Grand Total
Advocacy/Policy Dialogue and Advice	234,084	1,080,741	192,929	1,507,754
Knowledge Management	1,106,826	1,569,514	500,370	3,176,710
Capacity Development	3,141,433	4,584,958	3,293,045	11,019,436
Service Delivery	3,611,899	9,612,602	5,350,559	18,575,060
Other (including Operations, HR, M&E)	6,006,321	9,329,419	6,862,772	22,198,512
Grand Total	14,100,563	26,177,234	16,199,675	56,477,472

Source: UNFPA Country Office (service delivery includes Humanitarian sector assistance)

Chapter 4: Findings- Answers to the Evaluation Questions

This chapter provides answers to the questions on evaluation criteria of relevance, effectiveness, efficiency and sustainability as well as a UNFPA specific evaluation criterion, Coordination which analyzes the strategic positioning of UNFPA Country Office within the UNCT and other development partners. Findings also cover aspects that are important to humanitarian setting, coherence, coverage and connectedness issues. Detailed evaluation matrices indicating the assumptions that were considered during the evaluation are in Annex 4. Furthermore, due to the page limit, additional information on findings under SRHR, A&Y, GE and P&D is included in Annex A –D for reference.

4.1 Answer to Evaluation Questions on Relevance

EQ1& EQ2: **Relevance**
EQ 1: In what way(s) was the UNFPA country programme able to (i) address the various needs of the population, including vulnerable and marginalized groups, (ii) align with government priorities; and (iii) respond to changes in the national development and humanitarian contexts during its period of implementation? *EQ2: To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?*

This section (4.1.1) describes the relevance of CP 9 for all outcome areas (SRHR, A&Y, GE and PD) together. However, detailed information on relevance under each outcome area is included in Annex E.

4.1.1 Relevance (SRHR, A&Y, GE and P&D)

Findings:

CP9 design and the interventions planned under all four outcome areas (SRHR, A&Y, GE and PD) are found to be highly relevant to the national priorities, the seventh five-year plan (2016-2020)[22], UNFPA mandate, and the needs of the beneficiaries – the rights holders. Keeping in line with the national strategies and policies, and aiming at the development of national capacity for policy advocacy and generation of population data for evidence based planning and budgeting, CP9 is designed based on the ICPD POA, 2030 Agenda for sustainable development, UNDAF (2017-2020), UNFPA SP 2014-2017 and 2017-2021, 7th FYP and specific international treaties related to CP 9 agenda. UNDAF was informed by a common country analysis carried out in 2015 by the UNCT and it reflects the UNFPA interests in terms of inclusion of the CP9 outputs under SRHR, A&Y, GE and PD.

Based on the stakeholders' feedback, and a detailed analysis of population data, CP9 selected needy populations (district selection) and addressed key issues identified in 7th FYP. Selection of UNFPA focus districts has been guided by social development criteria, with selection of upazilas, guided by issues of need and feasibility. The needs of the population, including the marginalized and vulnerable communities (based on criteria for selection of these target groups), were incorporated taking into consideration their priorities in the design and implementation of the UNFPA CP9 programme and reflecting these in the M&E of programme results. However, M&E system could be more geared

[22] General Economics Division, Planning Commission, Government of the People's Republic of Bangladesh, 7th Five Year Plan FY2016 – FY2020, Accelerating Growth, Empowering Citizens, Dhaka, December 2015.

towards the assessment of results for vulnerable groups, including disaggregation of data by sex, age and province/district. This is a gap that needs some attention to achieve "no one left behind" objectives by 2030. – P&D provided much needed data on various minority groups for planning purposes; it is still not adequate to map the inequalities and disparities. Without targeted data collection and monitoring for evidence based planning for service provision and measuring changes in the marginalized and vulnerable groups could limit the programme relevance to beneficiary needs.

With regard to SRHR, much of the attention in CP9 has been on getting systemic change in terms of availability of quality SRH services, with a focus on midwives. There has been less focus on the demand for and access to services, with the assumption that well-functioning systems will ultimately lead to increased patient flow, though with the recognition that access is not always achieved due to a variety of cultural, religious and financial barriers. -The SRHR programme component, with its focus on MNH, FP and integrated SRH services (such as fistula, cervical cancer and HIV/STI) with equity, is in line with the UNFPA strategic plan.

Adolescent and Youth interventions addressed unmet ARSH needs of vulnerable adolescent groups, as well as commitment to End Child Marriage and Gender based Violence and evidence (details under Effectiveness section) indicates that the Adolescent and Youth programme interventions are highly relevant for the context of Bangladesh where 35 percent of the population is adolescents and youth. The programme components are tailored to address the critical needs of adolescents and youth, especially young girls as a vulnerable category of the population due to their lack of access to information on sexual and reproductive health, quality ASRH services and vulnerability to violence. The programme targeted to build the knowledge base by introducing Standardized Life Skills Education (LSE), through school interventions, discussion sessions on gender equality to address violence against girls and women. A&Y programme also includes a comprehensive programme on ending child marriage, along with providing technical support to develop policy frameworks in favour of adolescents and youth.

As for GE, CP9 addressed vulnerable groups especially women and children in hard to reach areas and from vulnerable communities. In line with national priorities as outlined in the National Action Plan to Prevent Violence Against Women (2013 to 2025, the new time frame of the revised version is 2018-2030), GE interventions are in line with the principles of UNFPA strategic principles and UNDAF outcome no.1 "All people have equal rights, access and opportunities."

Selection of the strategic partners (BBS, GED, Parliamentarians and the academic institution) is highly relevant given the expected CP9 outcomes. However, The National Population Council (NPC) (which is under the MoH) as the highest national body that deals with population issues has not been functioning effectively since 2010 and unless NPC is fully functional, implementation of national population policies may not be effective even if UNFPA assistance stays relevant to the government priorities.

While P&D programme outputs, as described under the effectiveness criteria, are clearly linked to priorities identified in the 7th FYP, UNDAF results frame, and addresses national development challenges within the capacity of UNFPA, some national development challenges not addressed in CP9 are issues related to ageing and internal and international migration. There are also areas that UNFPA assistance could produce better results if national authorities are in appropriate offices to fully deploy their functions, for example BBS, NPC could be made more functional and stay more relevant to the cause which will help UNFPA to be more effective in its technical assistance.

Analysis of data from an opinion survey (attitudinal survey) using the Likert scale, the majority (N=39 UNFPA staff – CO, Cox' Bazar and Field Officers, and other UN agencies including RCO) indicated that the CP has high relevance to the country priorities and needs. UNFPA IPs (N=14) also had a similar opinion. All offered ratings to effect "agree or strongly agree" to the statement related to the programme relevance. However, a few key informants from UN agencies did not agree with the statement that UNFPA has high relevance to the needs and priorities of the country. They felt that UNFPA operates in a comfort zone and there are some issues that are very much in the mandate of UNFPA that the country needs to address but, UNFPA has been weak to lobby or advocate for, specifically in two key areas on, Adolescents and Youth (A&Y) and sexual orientation issues.

Alignment with government priorities& UNDAF: The Adolescent and Youth (A&Y) Programme recognizes adolescents and youth as a vulnerable category, and addresses adolescent sexual and reproductive health (ASRH), violence against young girls, and child marriage which are critical areas of concern for young girls and boys in the country. The programme is fully aligned with UNDAF and government priorities as reflected in the Seventh Five Year Plan (2016-2020), Agenda 2030 including the SDGs.

Implementing partners mentioned the interventions as highly relevant since they are addressing a major critical area of concern for adolescent girls and boys. The rationale for this includes but is not limited to: as expressed in the UNDAF, adolescents in the poorest households have the highest unmet ASRH needs (as measured in infant and child mortality rates, and child morbidity), as a result of inadequate access to and poor quality of antenatal, prenatal, child and maternal health services. UNDAF continues to contribute to GOB priorities and does include mandate areas of UNFPA, including MNH, FP, adolescent sexual and reproductive health, health sector response to gender based violence and diagnosis and treatment of people living with HIV. Moreover, it pays attention to removal of discrimination enshrined in laws as well as enabling factors for programme implementation, including overall health expenditure as well as gender budget, including aspects concerned in the UNDAF results framework.

UNFPA interventions in the humanitarian sector maintained high relevance by contributing to the needs of the GoB and the people needing assistance. UNFPA responded with the posting of midwives in the existing government and NGO health facilities, which meant that pregnant women could receive SRHR services, including lifesaving EmONC. Response was informed by a rapid assessment of existing facilities in the area of Cox's Bazar. Moreover, in December 2017, UNFPA started a population-based survey among the Rohingya refugees in partnership with the International Centre for Diarrheal Disease Research (ICDDR) of Bangladesh. The survey enabled to ascertain the demographic profiles of the refugee communities in order to explore the health needs and factual estimates of prevalence of pregnant women, lactating mothers and age-sex distribution of the population in order to support the government and humanitarian actors with relevant data to inform the planning of their responses.[23] Moreover, the response of UNFPA in host communities was informed by UNFPA's SRHR initiatives that existed before the major influx of Rohingya refugees in August 2017.

In addition to the response to the large influx of Rohingya refugees after August 2017, in that same year UNFPA responded to four other emergencies, including the situation of Rohingya refugees existing in

[23] UNFPA Bangladesh 2017 Annual Report SIS, January 2018.

early 2017, cyclone Mora in June, including nationwide floods, and landslides in Rangamati, CHT and flooding in Sylhet division.

During the period of CP9, Bangladesh had to face the rapid influx of Rohingyas fleeing military repression in the Rakhine state of Myanmar thus creating grounds for a massive humanitarian response in the south eastern district of Cox's Bazaar, Bangladesh. UNFPA responded to the crisis through its mandate as the global leader for SGBV. It took the role of coordinator of GBV, a sub sector of protection issues in the International Sectoral Coordination Group. UNFPA has been providing life-saving sexual and reproductive health services supplies and information as well as prevention and response to GBV to support survivors on the path to healing, recovery and empowerment. Signature interventions in this latter aspect have been Women Friendly Space (WFS) through which 59, 939 and 106,495 women and girls accessed a safe haven space in 2017 and 2018 respectively.[24] Women Led Community Centers through which around 2000 women and girls participated in skills training serving the needs of the beneficiaries.[25] While UNFPA provided around 100,000 dignity kits, GBVIMS monitoring was conducted in 8 facilities in 4 camps.[26]

4.2 Answer to Evaluation Questions on Effectiveness

EQ3: **Effectiveness**
EQ3: To what extent have the expected outputs of the 9th country programme been achieved in the development and humanitarian contexts? And to what extent have these outputs contributed to the achievements of the outcomes of the 9th country programme?

The following sections describe the extent to which CP9 achieved its intended results separately under each outcome area. Due to the CPE page limit, additional details of results achieved under SRHR, A&Y, GEWE and PD outcome areas during CP9 are available in the Annexes A – D respectively.

4.2.1 Sexual and Reproductive Health and Rights (SRHR): Effectiveness

Summary of findings: The SRHR outcome area of the programme consists of three components which each have their own results framework. Though an overall framework has been developed, it does not identify how the various components interrelate to achieve the outcome level change.

-Reduction of Regular Resources for the 9th country programme resulted in scaling down of parts of the programme, in particular those parts primarily funded through regular resources, including cervical cancer and fistula. However, through the mobilization of additional other resources from development partners, the country office is confident that original targets can be met. Results in the outcome areas of MNH and FP were less affected by resource constraints and proved largely on track.

-In terms of targeting at sub-national level use was made of piloting as well as service provision approaches. Though this was relevant in the contexts concerned, the opportunities for scaling up and sustainability of results of each of these approaches remained unclear.

-The SRHR component consistently has been working on supply and demand side issues, paying attention to capacities to deliver services as well as engaging communities and left behind groups in terms of their reproductive health seeking behavior.

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[24] UNFPA 2017, 2018 Annual Reports

[25] UNFPA , Annual report2018, progress and highlights, Dhaka, Bangladesh,p.18

[26] Information received through CO in June post field visit.

SRHR initiatives, focused on policy issues at national level as well as at implementation at sub-national and community levels, were centered on selected 19 focus districts making use of a range of criteria. The three output areas that feed into the SRHR outcome area are maternal health, family planning and integrated SRH services with equity. Each of these output areas has its own results chain, which is used in monitoring and evaluation of the results concerned. Moreover, there is an outline of an overall theory of change of the SRHR outcome area, which provides an overview of the three output areas. This outline, however, does not clearly show the interconnections between and across the three output level changes and the contributing factors to achieving them. Though there is an overall effects diagram which indicates some of the linkages between the programme components, this could be further enhanced to identify how results in one part of the programme can reinforce or constrain other parts of the programme. The lack of such interrelationships at times has reinforced a compartmentalized approach in the outcome area.

The SRHR component has been affected by a reduction of regular resources, which reduced in particular on cervical cancer and obstetric fistula interventions, which depended heavily on regular resources. The targets in the results framework were, however, not adapted to the changes in resource situation, as this would have required renewed negotiations with the government of Bangladesh on the CPAP, which had been agreed in early 2017. During the implementation, however, the country office could realize substantial additional funding from development partners and increase the level of other resources. Therefore in terms of SRHR, CO was confident that it could still reach the targets set for the various outputs level changes in the results framework in each of the components of the SRHR outcome area.

The SRHR component has worked at the national policy level, including in terms of supporting policy change required for the establishment and functioning of midwife positions. Targeting at the sub-national level in the SRHR programme appears to have made use of two principles: 1. Focus on a piloting approach to bring issues to scale, particularly in terms of the development of a model for midwife led continuum of care, and 2. Focus on the most left behind areas and groups, to enhance their access to services and 'filling existing gaps' in the present health care system. This combination of approaches, while relevant in terms of targeting, needs to bear in mind the limitations concerned in terms of learning of which approaches work or work best and making use of such learnings for expanding support concerned to other areas. While piloting is useful to inform scaling-up in other areas with similar conditions, programming for vulnerable and most left behind groups is primarily done to support these groups with services. As this approach makes use of the specific requirements of the group concerned, there is fewer prospects for scaling up to areas beyond this specific group. While this can be a relevant approach in terms of reaching vulnerable groups in line with the Agenda 2030 principle of 'leaving no one behind', this approach is more limited in terms of its ability to inform future scaling up of programming. In each of the results chains of the components of the SRHR programme there is attention to support the capacities for the provision of quality reproductive health services in place while on the other hand there is attention to the demand for such services, enhancing the health seeking behavior in terms of the use of reproductive health services. The latter in particular of importance for left behind groups and communities, and in hard to reach areas.

MATERNAL AND NEONATAL HEALTH[27]

Summary of findings: Maternal and Neonatal Health (Findings triangulated)

- In the MNH component of the outcome area, the country office has made use of a comprehensive approach towards establishment of midwifery as a profession and to support a midwife- led continuum of care, including support to the legal and policy framework, faculty development through nursing and midwifery (NM) institutes and colleges, strengthening the capacity to deliver EmONC and community engagement.

- The training component for midwives has made use of a systemic approach, including support to the development of a midwifery curriculum; develop lesson plans, assessment methods and strengthening capacity of the faculty, building the capacities of NM institutes and colleges to deliver the curriculum and in the process of a PhD component on research and accrediting NM colleges.

- Results have included the posting of registered midwives at upazila levels, which has enhanced service delivery and facility-based delivery, with use made of a context specific approach in terms of posting midwives at lower administrative levels in hard to reach areas and providing services to particularly vulnerable groups.

- There is a need to keep the increasing demand for midwifery services in health facilities in pace with the capacity to deliver such services, with reproductive health service provision already under substantial pressure, with the risk of sudden increase in demand undermining quality of services provided.

- Community outreach to enhance demand of midwifery services proved less successful and results varied at sub-national levels visited by the evaluation team. Partly this related to targets that were higher than what was desirable given the more limited increase in supply of midwifery services at the sub-national level. It will be important to align activities in terms of enhancing demand, with increased supply at the sub-national level and to make use of the monitoring system to inform initiatives concerned.

SRHR on Effectiveness in Development Programme Maternal and Neo-Natal Health

The maternal and neonatal health component of the SRHR outcome area has focused on the development and use of a midwife led continuum of care, including EmONC. This concerns a continuation of an initiative started in the previous programme cycle and focused on the establishment of midwifery as a profession in Bangladesh.[28] In order to achieve this, UNFPA in the present programme cycle focused on enhancing the number and capacity of midwives, increasing the availability and quality of EmONC services and enhancing the demand for facility based midwifery services. The country office has worked with a variety of partners in each of these result areas.

Aspects of Midwifery Regulation supported by UNFPA

- By-law for the Nursing and Midwifery Acts
- Midwifery Policy
- Accreditation guideline for midwifery education
- Standardized midwifery examination system
- Midwifery career path guideline
- Guideline for supportive supervision for midwifery education
- Revision to the licensing guideline
- A midwifery code of ethics

Source, UNFPA Bangladesh, SIS Annual Report 2017, Jan, 2018.

To improve the number and capacity of midwives, UNFPA focused on aspects of policy, academic faculty development, and positioning of midwives in the

[27] Additional details are presented in Annex A-2.
[28] Note on definition of midwifery (see Dalarna documentation).

health care system. Policy aspects focused on support to a number of legal and policy issues that provided an enabling environment for the development of midwifery as a profession nationally and at the health facility level and provided guidance to the process.

To develop the capacity of midwives, rather than to train midwives, UNFPA supported the development of the education system required for the training and posting of midwives. UNFPA worked with DGNM and Dalarna and Auckland Universities to enhance the capacities of the Nursing Institutes and Colleges, in the process renamed to Nursing and Midwifery Training Colleges.

Though the support to the setup of a faculty for midwifery has taken a substantial effort and a longer time frame compared to training of midwives by UNFPA, it represents a more systemic approach to improving the quality of midwifery education, with the expectation of a multiplier effect, enabling the on-going training and posting of midwives in health facilities in Bangladesh over time. With the first two batches of registered midwives posted in selected health facilities across the country, the approach has started to deliver its first results.

To enhance the capacity of midwives and enhance their position vis-a-vis nurses and doctors, UNFPA partnered with the Royal College of Midwives to strengthen the capacity of the Bangladesh Midwifery Society (BMS) as a professional organization. The young leadership programme of the BMS and an online learning course launched were important means to further enhance capacities of midwives enabling them to take up their position in health facilities concerned. The support to the BMS through the twinning with the British Royal College of Midwives is an important enabler for the further professionalization of midwifery and to enhance the status of the profession of midwife in a hierarchically oriented health sector.

There remain issues to be addressed, including ways to ensure the actual ability of midwives to apply their learnings and skills in practice, with at times nurses and doctors resisting evidence based practices that the freshly trained midwives want to implement. Also the issue of 'deshouldering', i.e. the practice of declining women in labour for fear of the patient dying in the facility, remains an issue, which at least in part relates to the limited capacity of facilities and the lack of 24/7 support and a lack of the full integration of midwives allowed to stabilize patients in emergencies. The mentoring system that was put into place was meant to support midwives in this respect and proved an indispensable means for the newly posted midwives. Moreover, an extensive monitoring system has been put into place which is meant to assess changes at the level of districts, upazilas and facilities (further discussed under the evaluation criterion of efficiency).

In order to monitor maternal deaths and respond, UNFPA supported the implementation of the maternal and perinatal death surveillance and response (MPDSR) in 5 target districts in 2017, 10 in 2018 and 12 in 2019, making use of the national guidelines. This included training of doctors and nurses at district and upazila levels in the districts concerned. The MPDSR has become a GOB led programme through the MDPSR committee. Government of Bangladesh, UNFPA, UNICEF and SCI took up responsibility of sharing districts for roll out MPDSR to ensure complementarity and in this way to cover

all target districts.[29] UNFPA has provided support to the Maternal and Perinatal Death Review and Response since 2010, which is presently a GOB programme, led by the MPD committee at district level. The Maternal and Perinatal Death Review data are important to guide the support provided to MNH.

Results in terms of the enhanced recognition of midwifery as a profession concern the inclusion of midwifery into the Disbursement Linked Indicators of the GOB operational plan and the renaming of the Directorate of Nursing Services to the Directorate General of Nursing and Midwifery while a dedicated midwifery unit has been established at the Directorate General of Nursing and Midwifery (DGNM) with an office space and posts for a Deputy Director for Midwifery. Moreover, a Midwifery Programme Focal Point was created to oversee the midwifery education and services at the national level. The Bangladesh Nursing Council became the Bangladesh Nursing and Midwifery Council.

Notwithstanding the success of the MNH component so far, the further institutionalization of the approach needs to be monitored and if necessary followed up. While, for example, the first batches of registered midwives were deployed under the auspices of the DGNM, this appeared to have taken considerable time in the case of later batches. Moreover, during the fieldwork of the evaluation, a teacher at one of the Nursing Midwifery colleges, which had participated in the MSc course, indicated that there were issues with pay of teachers, an issue related to GOB budget issues. However, the spread of the issue could not be verified by the evaluators. Both examples point to the issue that on-going monitoring and follow-up is required in terms of the actual implementation of the midwifery training and the placement of midwives. This concerns the connection between the educational faculties and MOH in the education, recruitment, deployment, supervision and retention planning.

A comprehensive approach was also followed in terms of the UNFPA support to enhancement of EmONC services, which included support to GOB policies and plans, 24/7 EmONC services in facilities, availability of reproductive health commodities and a harmonized monitoring system in place. In order to guide this part of the programme, the development of the post-partum hemorrhage and eclampsia action plan was supported. This plan was a response to a maternal mortality and morbidity survey that revealed that 55 percent of all maternal deaths were caused by either hemorrhage or eclampsia (at 31 and 24 percent respectively). The plan focused on 5 strategic objectives, including related policies, health facility capacities and access to relevant 24/7 services for all women as well as health seeking behavior and referral practices for pregnant women.[30] The development of the plan was followed up with support to the development of district action plan in the 19 focus districts of UNFPA. Support was provided to mentoring of midwives, including promotion of the use of the partograph through the professional organization of obstetricians and training of government warehouse managers in logistics management.

The third component of maternal and newborn health concerned support to increasing the demand for facility based maternal health services at the community level. This was meant to be achieved through increasing the awareness of community members of danger signs of pregnancy, which would indicate

[29] UNFPA, WHO and UNICEF supported the Ministry of Health in designing the national guidelines, in which respect UNFPA led one of the three sub-groups tasked to develop different sections of the guidelines for review by the steering committee.
[30] Directorate General of Health Services, Directorate General of Family Planning and Directorate General of Nursing and Midwifery, Eclampsia and PPH Action Plan in Bangladesh 2017-2022, Dhaka, 2018.

the need to seek maternal health services and thus increasing the demand for such services. UNFPA supported the country-wide family planning and maternal and child health service campaign to create awareness and enhance demand on facility based delivery. Moreover, UNFPA partnered with the BBC Media Action, to provide SRHR related information to adolescents and youth through the use of social media. The limitations in access to social media for women and girls and in particular for rural women and girls, has affected the result of the social media campaign for this target group.[31]

An underlying assumption appears to be that if services are available and of sufficient quality women and girls will make use of them. This does not necessarily hold true in particular for poor and marginalized groups, which often do not access services for a range of economic, social and cultural reasons, and may need additional information or other support in order to access services. On the other hand, one needs to ensure that demand does not increase more rapidly than the supply of services. There remains a need to pay sufficient attention to the community level part that has been included in the results chain. Monitoring data through IEDCR mobile phone based assessment in the last quarter of 2019 will be important to assess results and to inform this part of the programme component.

When assessing the output level indicators of the UNFPA CPAP results framework, it can be observed that in terms of support to midwifery most of the indicators could be met. This is less the case for the indicators related to getting EmONC services in place, where in particular the number of UNFPA focus districts which have an established network of facilities providing 24/7 EmONC services is lagging behind as well as districts that implement MPDSR according to the national guideline. The least successful aspect of the MNH part of the programme appears to be the community mobilization part, with indicators concerned regarding identification of danger signs in pregnancy and identification of activities to prepare for birth proved far from met. For details see the table in Annex A-3.

Facilitating Factors: The support to MNH in the eighth UNFPA country programme builds on the work done in this respect in the previous country programme; The establishment of midwifery as a profession in Bangladesh is owned by the government and several adaptations have been made to the organization of the Ministry of Health and the DGNM to enable this.

Constraining Factors: Registered midwives and EmONC compliant facilities at sub-national level (like governance and management of facilities), sufficient staffing , hygienic conditions of facilities, and facilities' case capacities as well as access to roads, electricity and water. For real change to occur, there is a need for significant numbers of midwifes posted at sub-national levels of the health system. Since Sept 2018, a total of 1,738 midwives of which 1,149 registered midwives have been posted while according to DGNM about 25,000 are needed. With the present training capacity, it would take about 25 years to achieve this amount (38 institutes with a capacity of 25 midwives per year).
A focus on vulnerable and marginalized groups needs to be informed by a monitoring system that can disaggregate health data accordingly. However, the HMIS of DGNM does not identify vulnerability characteristics of women. Though such data are available at facility level, they are not taken up in the HMIS. This limits DGNMs ability to monitor and address aspects of vulnerability.

[31] BBC Media Action Research and Learning Team, Improving reproductive and maternal health and gender based violence in Bangladesh: Evaluation of the BBC Media Action Hello Check Facebook page, December 2017.

SRHR OUTCOME AREA 2: FAMILY PLANNING

Summary of findings: Family Planning

-Policy level issues achieved included FP policy in place; National action plan on post-partum family planning; Policy to allow midwives to provide PPFP

-UNFPA supported demand side issues, including through hiring 18 FP temporary facilitators to support dissemination at local level covering 24 underperforming districts and the provision of a 'gift box' to newly-wed couples with FP information on FP and contraceptives, promoting postponing pregnancy and through social media, with the latter showing limited reach of adolescent girls.

-Most of the policy and supply side related indicators of the CPAP framework achieved, Regarding demand side issues, access to FP counseling was not met and access to information not yet clear due to lack of data so far.

SRHR on Effectiveness in Development Programme Family Planning

The Family planning component of the SRHR outcome area has focused on increasing the demand for, as well as the supply of, family planning information and services. This was meant to be achieved on one hand through support to increased awareness on family planning information and services, in particular regarding modern contraceptives. On the other hand, attention was paid to enhancing the supply side of quality family planning services and information, in particular access to Long Acting Reversible Contraceptives (LARCs), which use in Bangladesh was at only 8 percent. Though GOB remains committed to Family Planning, with targets set for 2020, this commitment is less strong than in the past.

Thus, part of the programme focused on community awareness raising and engagement with key motivators at the community level, including gatekeepers and community support groups. An important initiative in this respect, informed by a study on ways to delay early pregnancy, concerned the provision of a gift box to newly-wed couples at the marriage ceremony, which box contained IEC materials and FP methods, including pills and condoms and information on the use of LARCs, promoting postponing pregnancy till the mother's age of twenty.[32] Though the amount of gift boxes spread was limited, a study was conducted on the results of the initiative. This showed a 13 percent decrease of pregnancy rates in intervention versus a non-intervention group (16 versus 29 percent).[33] DGFP has shown interest in the results and appears willing to scale up the use of the approach.

At the supply side the programme focused at support to the National Policy on Family Planning, with an emphasis on quality issues, which policy was drafted in 2018 and endorsed by the MOHFW in the second quarter of 2019. The national action plan on postpartum, menstrual regulation, post abortion care and family planning was endorsed, printed and disseminated.

UNFPA, moreover, supported the drafting of standard operating procedures and counseling materials, to improve quality of FP services, in line with the national FP policy. UNFPA advocacy in parliament

[32] Couples were identified through the marriage registrars and imams/purohits. Newly wed couples were counselled at home shortly after marriage by FWAs, who also motivated mothers-in-law to support the married couple in preventing early pregnancy. This is of particular importance since the young couple is traditionally meant to show early on their fertility, with about 60 percent of the young married girls pregnant within 6 months after marriage. Source: Interview data.

[33] Source: details research report.

resulted in the sub-committee on maternal health of the Bangladesh Association of Parliamentarians on Population and Development (BAPPD) to include family planning, which provided UNFPA with an access point in Parliament for future FP advocacy.

With UNFPA support, a new policy was approved which allowed midwives to provide family planning services, which is expected to contribute to the improvement of post-partum and post-abortion family planning services through the midwifery cadre.[34] This, moreover, enhanced the opportunities for women to also receive FP services in district hospitals and upazila health complexes, which are under DGHS rather than DGFP. UNFPA supported DGFP to deploy FP counselors at these health facilities in order to enhance FP services in DGHS facilities. This is in particular important in terms of postpartum family planning, providing FP services for mothers who delivered in DGHS facilities.

FP Awareness Programmes

UNFPA, moreover, supported GOB to reach its FP 2020 objectives through the development of an action plan for acceleration of FP achievements and building partnerships to enhance programme implementation and monitoring. As part of the programme, 18 FP temporary facilitators were hired to support dissemination at local level covering 24 underperforming districts, with one supervisor.[35] Focus was, moreover, at the uninterrupted supply of contraceptives, through district level action plans and support to enhance the use of LARCs and permanent contraceptive methods through client fairs and stationing of one FWV in each of the model clinics identified.

In terms of results on the output level indicators of the UNFPA CPAP results framework the achievements vary. While policy level objectives were achieved, results in terms of counseling and access to FP information were not or not yet reached. The provision of four contraceptives at UH&FWCs in CP9 districts was achieved according to the data presented (see Annex A-2). Thus aspects of policy and supply side issues proved to perform better than aspects of enhancing awareness and demand for FP services. In the latter respect, there was only limited reach of rural female adolescents through outreach activities. This with the focus on social media, which are used more often and actively by male compared to female adolescents in particular in rural areas.[36] Though UNFPA advocated towards DGFP since mid-2018 to ensure increased community outreach activities by Family Welfare Volunteers and other health care workers, the indicator could not be reached by mid-2019. For details see Annex A-3.

Facilitating Factors: Government support for Post-Partum Family Planning is an important enabler of family planning and the use of longer term methods. The approach of provision of a gift box to

[34]The national action plan on postpartum, menstrual regulation (MR), post abortion care and family planning was endorsed, printed and disseminated.

[35]The job description of the family planning facilitators included technical assistance to PF managers in the planning, implementation and monitoring and supervision of family planning services at different tiers, assist in population based eligible couples targeting, support to periodic campaign for LARCs and PM in hard to reach areas, support monthly coordination meetings and provide monitoring support and coordinate government, civil society and other FP related initiatives at district, upazila and municipality levels. Job Description of Family Planning Facilitator, MOHFW, DGFP.

[36]BBC Media Action, Research and Learning Team, Improving reproductive and maternal health and gender based violence in Bangladesh: Evaluation of the BBC Media Action Hello Check Facebook page, December 2017.

newlywed young couples in order to promote the postponement of pregnancy, was positively received by GOB and might be taken up for scaling up.

Constraining Factors: Focus is on married adolescents as addressing of unmarried adolescents is considered a no-go issue in the present context of Bangladesh. Reaching adolescents with FP information and services is a real challenge as it is a taboo to talk to adolescents about sexuality. Unmarried youth depend on NGOs or the private sector in order to get access to contraceptives. In terms of outreach activities, focus has been on BBC media action, making use of social media. Study conducted by BBC Media concluded that girls have less access and make less use of this type of media and when they use it they appear less active users in terms of postings.

SRHR OUTCOME AREA 3: INTEGRATED SRH SERVICES WITH EQUITY

Summary of findings: Integrated SRH Services with Equity

Cervical Cancer

- Cuts in funding of regular resources has caused UNFPA's intervention in the area to be at a national and strategic level only in the first one and half years of programme implementation till DFID funded a project to intervene on cervical cancer issues. With the new funds, the country programme is planning to achieve the results set out for the CPAP.
- The National Cervical Cancer Strategy got into place with approval in 2018 as well as the related action plan, supported by UNFPA in cooperation with WHO
- CPAP output indicators on strategy, reporting, basic treatment at tertiary level and screening at district hospital level met, but screening at UHC and advanced screening and treatment at District Hospital not met
- There is a need to balance the capacity for screening with the capacity for treatment of different stages of cervical cancer identified

Obstetric Fistula

- Support to reduction of Obstetric Fistula included support to the development of the 2nd National strategy 2017-2022, with a focus on identification, treatment, rehabilitation and reintegration into society
- Obstetric fistula contributes about 3 percent to MMR in Bangladesh, but relevant in terms of the long term suffering and exclusion of women and girls concerned
- Most CPAP indicator targets for 2018 achieved, except for the number of medical college hospitals providing treatment and integrated rehabilitation services

STI / HIV - Achievements

- A set of SRH services under the equity component include sexually transmitted infections (STIs) and HIV, health sector response to GBV and access to SRH services for urban slum dwellers and populations affected by disaster. All these initiatives are aimed to contribute towards an enhanced institutional capacity to deliver integrated and equitable SRH services.
- SRHR support provided by UNFPA in Cox's Bazaar as well as in other emergency situations enhanced the coverage and use of SRHR services in the areas concerned.

SRHR on Effectiveness in Development Programme: Integrated SRH Services with Equity

The third component of the SRHR outcome area of the Bangladesh Ninth Country Programme concerns a combination of elements organized around the theme of equity, with all elements consisting of distinct sexual and reproductive health services. The component includes access to and use of services concerning cervical cancer, obstetric fistula, sexually transmitted infections (STIs) and HIV, health sector

response to GBV and access to SRH services for urban slum dwellers and populations affected by disaster. All these elements concern important SRH services as such and in this way contribute to the results of the outcome area, i.e. increased availability and use of integrated SRH services. Each of these elements is not linked to the outcome level indicator, i.e. *percent of live births attended by skilled birth personnel*, which fits well with the MNH component. The outcome level indicator of the Results and Resources Framework of the UNFPA Strategic Plan 2018-2021 regarding Number of women, adolescents and youth who have utilized integrated sexual and reproductive health services, would appear more useful. Below key issues on each of the services are provided with details in annex A-5.

Cervical Cancer: With the reduction of the regular funds received from UNFPA headquarters, this part of the programme carried some of the consequences concerned. Given fund limitations, national level activities were prioritized. With additional funding realized from DFID in Q4 2018 which will last till 2022, the country office is confident that towards the end of 2020 most of the targets as included in the CPAP results framework can be met. In terms of CPAP output level indicators, targets on strategy, annual reporting, basic treatment at tertiary level and screening at district hospital level were met, but screening at UHC and advanced screening and treatment at DH could not be met. For details see the table in Annex A-3.

Obstetric Fistula; The reduction of UNFPA regular resources to the Bangladesh country office also affected the fistula component of the SRHR outcome area. The fistula component focused on identification, treatment, rehabilitation and reintegration of patients in society. The NGO LAMB has made a clear linkage in their programming between fistula incidence and child marriage, both being high in Char areas where education levels are relatively low and communication in large parts of the year poor. In this respect they focus on prevention of child marriage as a means to reduce the obstetric fistula prevalence rate. According to an unpublished maternal mortality survey, fistula contributes only about 3% to MMR, but the focus on fistula is justified in terms of focus on a specifically vulnerable and marginalized group, with a specific relation to the mandate are of UNFPA.

In terms of targets of the CPAP results framework, those on identification of patients were met as well as those on rehabilitation received by fistula survivors met. However, targets on fistula surgeons and treatment provided in medical college hospitals were not met. The number of district hospitals with a functional fistula corner has been improving, and fistula was included with indicators in the national registry, though reporting standards remained low. While obstetric fistula, which appears to be decreasing, surgical fistula which is caused by surgical mistakes and appears amongst others related with the high incidence of C-sections, is increasing. For details see the table in Annex A-3.

Other SRH Services; UNFPA focused on STI with MOHFW focus on HIV/AIDS. An STI strategy and action plan was developed and plans for a surveillance system in concept stage together with IEDCR realized. As government HIV prevention services discontinued in large brothels from Nov 2017, UNFPA supported brothels in Tangail/Mymensingh on HIV prevention for sex workers as well as access to SRH services through work with CBOs and peer groups. Targets on CPAP indicators were mostly reached, except for a national STI surveillance system and costed action plan in place.

In terms of support to the health sector response to GBV, a protocol was developed by the end of 2017, which provided details on actions for health care providers on physical examination, treatment and multi-sectoral references. Moreover, service providers were trained on the use of the protocol in

selected districts, with the MOWCA supported One Stop Crisis Centers (OSCC) providing services in nine medical college hospitals and OSCC cells providing information in 40 districts hospitals and 20 upazila health complexes as part of their multi-sectoral VAW programme. Targets on CPAP indicators regarding number of district health facilities providing integrated SRH and GBV services not reached (achieved in 6 rather than 10 districts).

Facilitating factors in Integrated SRH Services with Equity: CO was able to mobilize other resources which could fill the gap created by the reduction of regular resources received and maintain this part of the programme, though implemented with a delay in timing.

Constraints in Integrated SRH Services with Equity: Cuts in funding of regular resources from UNFPA headquarters meant that various initiatives of the SRHR outcome area needed to be postponed and programme adapted to the resource envelope. Sub-national coverage of the various parts of the SRHR programme vary, which means that a convergent approach of the components cannot be realized across the programme.

SRHR in Emergency Preparedness and Response (Cox's Bazar and other districts)

This part of the programme focused on provision of comprehensive SRH services to refugees in Cox's Bazar, improvement in coordination, advocacy for SRH in emergency situations and enhancing the national capacity for MISP in terms of emergency preparedness and response.

In order to enhance disaster preparedness, UNFPA support has focused on 13 disaster prone districts. In 2017, 40 health facilities were supported to provide BEmONC and two referral hospitals to provide CEmONC to disaster affected women and girls in refugee, flood, and cyclone affected areas, with a provision of cash grants to 7,000 pregnant women. In 2018, training was provided to 100 health providers on rapid response in emergency and RH commodities were pre-positioned for immediate use in case of an emergency.[37] An additional 110 health service providers were planned to be trained on the reproductive health minimum initial service package (MISP) in 2019.[38]

While the number of disaster prone districts with MISP implementation capacity was targeted to be 17 for 2019, in June of that year it had reached 12. At the same time, another SRH in emergencies related indicator concerned the cumulative number of midwives trained in the provision of 24/7 EmONC services in emergencies. This reached 92 midwives in June 2019, while the target was at 150 for 2019.[39] In several of the district visited by the evaluation team there appeared limited understanding on the need for disaster preparedness in terms of SRH services and protection measures for women and girls. Given the disaster proneness of Bangladesh there appears a need for additional attention to the issue of disaster preparedness and the use of MISP at the sub-national level.

There has been a functioning SRH working group at the national level since the second quarter of 2017, with meetings conducted regularly. Inter-agency risk analysis was conducted in 2018, led by UN RCO office and contingency plans reviewed, with the UNFPA mandate areas included. UNFPA has explored possibilities for partnership on humanitarian issues with agencies or organizations with a presence in

[37] UNFPA Bangladesh, 2017 Annual Report, January 2018; UNFPA Bangladesh, 2018 Annual Report, February 2019.
[38] UNFPA Bangladesh, 2019 Annual Planning, April 2019.
[39] CPAP Results Framework, UNFPA Bangladesh Country Office.

disaster prone districts and identified CARE Bangladesh as a potential partner, which can enhance UNFPA's ability to support humanitarian response on the ground when disaster strikes.[40]

SRHR in Emergency Response in Cox's Bazar (CXB):

UNFPA provided support to SRHR facilities for Rohingya refugees, displaced persons and the host community, informed by Assessment of quality aspects of individual facilities conducted by PHD. UNFPA had been working with RTMI to provide SRHR support to Rohingya refugees in CXB since 2008, in two registered refugee camps so RTMI had a presence in CXB and an on-going relationship with UNFPA. This facilitated scaling up of support through RTMI when the influx of Rohingyas dramatically increased in August 2017. After this large influx an estimated 24,200 pregnant women were there. Initially, midwives provided services in the absence of doctors, using natural virginal delivery (NVD). Critical patients were stabilized after which they were referred. FP support was provided to women that delivered. About one thousand deliveries in all by registered midwives, who were trained in the UNFPA supported training programme with multiple batches stationed in CXB Bazar to support delivery of Rohingya women, which exposed their capacities worldwide. Moreover, UNFPA supported the deployment of doctors; provision of essential equipment, medicines and vouchers for transport in case of referrals.

Inside CXB camp facility-with a new born baby

UNFPA worked with partner NGOs like RTMI who deployed 225 staff at site providing SRHR support including maternal health, adolescent health, FP and STI prevention, aimed at higher rates of facility based deliveries and increase in acceptance of FP, with a focus on adolescents and youth and inclusion of refugees as well as host communities.

Support to FP through partners including RTMI, HOPE Foundation and IPAS, capacitating service providers of government, counseling with the use of flipcharts and videos in Rohingya language, billboard messages and counseling at dwellings. Support continues through UNFPA and other development partners, including WB. Rohingyas have had little exposure to FP as their access in Rakhine state to SRH services was limited.

Delivery of services has included ANC, delivery/EmONC with referral if needed, PNC, menstrual regulation, PAC and family planning (5 methods), with application of a stigma free approach.

Focus has included training of community health workers (from Chittagong / Rohingya communities) for outreach. Nevertheless, facility based delivery by Rohingya pregnant mothers remained limited, which remains an issues to be addressed; use could possibly be made of TBAs in order to connect with pregnant women and facilitate their use of the facility for delivery (as trialed elsewhere in Bangladesh). Gaps remain in the quality of SRH services in the various health facilities, including provision of 24/7 EmONC services at upazila and district levels. The system of maternal death review remains hampered through limitations in the initial notification of possible maternal deaths.

[40] UNFPA Bangladesh, 2017 Annual Report, January 2018; UNFPA Bangladesh, 2018 Annual Report, February 2019.

Other humanitarian action supported by UNFPA

In addition to the response to the large influx of Rohingya refugees after August 2017, in that same year UNFPA responded to four other emergencies, including the situation of Rohingya refugees existing in early 2017, cyclone Mora in June, and landslides in CHT and flooding in Sylhet division. UNFPA response included provision of SRHR services, emergency GBV case management services in set up women friendly spaces, training, medicines and commodities for clinical management of rape services and the provision of dignity kits. In May 2017, the UNFPA-led GBV cluster and the UNICEF-led Child Protection cluster established a joint task force to advance advocacy on protection issues.

Facilitating factors humanitarian support Cox's Bazar:

- UNFPA support has been informed and facilitated by existing support to the Rohingya community in Cox's Bazar before the influx of 2017 and existing partnerships with UNHCR, IOM, NGO implementing partners and local communities which enabled UNFPA to quickly scale up its presence as partnerships were already in place.
- Work with Rohingya volunteers made engagement with the refugees easier.
- The use of food vouchers instead of cash transfers with the latter more easily used for other purposes

Constraining factors of humanitarian support Cox's Bazar:

- Given GOB limitations, focus remains on temporary support with limited opportunities for a longer term perspective, though this appears to slowly change.
- Many of the Rohingya refugees are illiterate which requires adaptation of behavior change communication approaches.
- There has been an initial lack of awareness among Rohingya refugees regarding availability of SRH services and rights of access, as they had little access to such services in Myanmar. They are a relatively conservative group with high birth rate and reluctant to use contraceptives for FP. However, interest in and use of FP has gone up, according to the feedback from the field.
- Staff retention in Cox's Bazar is difficult with many agencies recruiting form a limited pool of applicants.

4.2.2 Adolescents and Youth: Effectiveness

Summary of findings: The cumulative achievement of most of the output milestones till 2019 (Q2) have been either fully achieved or are on track. Seven key target districts have been selected where a large proportion of vulnerable population groups reside based on an extensive geographic mapping exercise for A&Y downstream implementation work; while upstream advocacy focused on transformative policy and budgeting.

UNFPA has done commendable work in supporting the GoB to enact laws and policies to protect and enhance the rights of women and girls, adolescents and youth, as well as creating an enabling environment for preventing sexual harassment in schools, through Life Skills Education interventions in secondary schools. UNFPA partnered with other UN agencies and Development Partners to support the government in drafting and enacting key policy documents - the National Youth Policy, the Adolescent Health Strategy and the Action Plan, the National Plan of Action to End Child Marriage, the Adolescent Strategy, the Secondary Education Development Programme, and the National Action Plan for the Youth Policy. A&Y programme is designed in such a way that it has a particular cross cutting emphasis on meeting the needs and rights of adolescents and youth through both targeted programming and mainstreaming of adolescent focused interventions.

With over one third of girls in Bangladesh – married or unmarried – experiencing a pregnancy before the age of 19 and chances of complications during delivery are considerable. In the absence of adequate information and RH services for unmarried adolescents, there is a great risk of unwanted pregnancies and subsequently often, unsafe abortions. Considering the urgent needs for ASRHR literacy among adolescents and youth, UNFPA has taken substantive efforts to make policy level as well as ground interventions targeting the adolescent girls and boys in its seven programme districts under CP9 including Cox' Bazar, Jamalpur, Bogra, Barisal, Barguna, Patuakhali and Dhaka. The scale of the interventions is quite limited and there are strong recommendations from both GoB and NGO partners to scale up the existing interventions under Generation Breakthrough project.

A&Y planned outputs contribute to the CP9 Outcome "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." As expressed in UNDAF, A&Y programme highlighted the importance of investing in adolescents and youth, especially for their health and comprehensive sexuality education, as well as promoting gender equality and preventing sexual harassment through school interventions. Seven key target districts have been selected where a large proportion of vulnerable population groups reside based on an extensive geographic mapping exercise for A&Y downstream implementation work, while upstream advocacy focused on transformative policy and budgeting.

Joint programming with other UN agencies: UNFPA partnered with other UN agencies and development partners to support the government in drafting and enacting some key policy documents - the National Youth Policy, the Adolescent Health Strategy and the Action Plan, the National Plan of Action to End Child Marriage, the Adolescent Strategy, the Secondary Education Development Plan (SEDP) and the

National Action Plan for the Youth Policy. The A&Y programme is designed so that it has a particular cross cutting emphasis on meeting the needs and rights of adolescents and youth through both targeted programming and mainstreaming of adolescent focused interventions.

As stated above experiencing a pregnancy before the age of 19 and the chances of complications during delivery are considerable: maternal mortality remains very high in Bangladesh. According to government policy only married girls are legally allowed to seek pregnancy related services in the health facilities, therefore all data (BDHS) related to maternal mortality and morbidity covers married girls only. In the absence of adequate information and RH services for unmarried adolescents, there is a great risk of unwanted pregnancies and subsequently often, unsafe abortions. Feedback from service providers revealed that through effective SRHR and GBV information, increased awareness, and adequate adolescent friendly health services, the programme interventions are contributing to a reduction of GBV, unwanted pregnancies, unsafe abortions, maternal mortality and morbidity and the spread of HIV and other STIs. For example, the numbers of GBV reported cases have been reduced; reported cases for complications during early-age pregnancy as well as adolescent maternal mortality have significantly gone down in the programme areas/communities, as evident in the registers kept by Union community health and family welfare centre.

A&Y programme addresses social norms and values and attitudes of adolescent boys and girls around gender equality and SRHR, and the linkages between GBV, gender equity and adolescents' SRHR. It provides life skills education programmes in schools, clubs and sporting programmes, as well as through public awareness campaigns. The interventions also address those adults that have a great influence on the lives of young people, such as: parents, teachers, community leaders and role models, thereby creating an enabling environment for positive change.

As reported by A&Y programme participants, adolescent girls and boys are able to access reliable and complete SRH and GBV prevention information in addition to counselling through a call centre based helpline. The lack of ASRHR information, stigma, taboo and misconceptions re ASRHR related issues, lack of reliable/available sources to consult on healthy sexual relations often causes an extra-ordinary amount of stress among the young population. UNFPA interventions under the A&Y programme is helping them to understand the importance of respectful, equal, consensual and healthy relationships as well as to break through the taboos around GBV and SRHR. A thirteen-year old student from Sher-E-Bangla Nagar High School shares her experience around the taboos around menstrual health.

"Many of my friends in my hometown used to have misconceptions around management of menstruation; one of them even thought that she is going to die out of bleeding! I am happy that I didn't have to suffer those fears, and now I can even help them to learn about menstrual health"

The A&Y programme highlighted the importance of investing in adolescents and youth, especially for their health and comprehensive sexuality education, as well as promoting gender equality through school interventions. The high rate of child marriage and gender-based violence in programme districts often contributes towards pregnancy related complications, psychological consequences and mental health problems. For example, child marriage affects three out of five girls; the share of adolescent

pregnancy, at 113 births per 1,000 women aged 15-19 years, is the highest in South Asia. More than 300,000 women and girls are believed to be affected by maternal morbidity, including obstetric fistula.

One of the initiatives appreciated by the implementing partners (IPs) is that, the A&Y interventions have been facilitating capacity building training for local level health professionals to ensure that the health service delivery points have at least one trained service provider who can provide AFSRH information and services in selected districts. The policy interventions initiated by UNFPA programmes emphasized on taking advantage of the demographic 'window of opportunity'.

IPs suggested the need for technical skills development training for girls and boys to be tagged along with Life Skills interventions in partnership with relevant development partners which would make the training programmes more interesting for project participants. A major challenge mentioned by the A&Y programme team is the bureaucratic procedures of the Government during the initiation of development partnerships which delays the implementation and delivery of project interventions. Despite the high commitment of the agency, the financial resources allocated for the A&Y programme was limited, therefore the interventions were small scale and partners strongly suggested the need for scaling up. However, the strategies pursued by the team have been successful in yielding the Government's interest to expand the A&Y Generation Breakthrough interventions in 6500 secondary schools countrywide which is currently under process. In addition, the Secondary Education Development Programme (SEDP) is planning to reach a total of 11,815 Secondary Schools by 2022.

A&Y response in humanitarian contexts:

The A&Y humanitarian interventions have been initiated since mid-2018 for the Rohingya and host communities in CXB. There was no apparent A&Y specific programme in the other districts except in CXB. The A&Y interventions have been primarily integrated within GBV emergency response programme by facilitating essential ASRH information, adolescent friendly health services and separate interventions on promoting life skills education for adolescent girls and boys in Rohingya and host communities through the following programmes:

-Girl Shine: aims to reduce the risk of violence for adolescent girls and provide them with the skills needed to ensure their well-being: A total of 1,319 participants attended 10 Girl Shine sessions (782 adolescent girls, 537 mothers and female caregivers)
-Champions of Change: focuses on building life skills and resilience of adolescent boys in line with the protection objective of the 'Joint Response Plan for Rohingya Humanitarian Crisis, March to December 2018'. A total of 8,540 adolescent boys have received 20 life skills sessions as part of the CoC curriculum.
-Young Mothers Support Group Project aims to build a better understanding of the importance of basic sexual and reproductive health and rights issues among young married adolescents and their support groups. A total of 105 community members were trained on gender issues, SRHR, violence prevention, and other risky behaviours, and about 150 were trained on awareness raising activities conducted by community facilitators and community based protection groups.
-Skilled Girls Force Project is engaging with unmarried adolescent girls to provide skills training, as well as providing gender equality, and prevention of GBV sessions to build their awareness and helping them to be empowered girls and ultimately work as a change maker in their communities.

Adolescent & youth as partners for development: IPs suggested the need for more engagement of adolescents and youth as volunteers, primary response actors, in the response, risk reduction and mitigation interventions in the context of emergency and disaster response. IPs also indicated the need for adolescents and youth to be engaged during the design phase of the interventions so that they can also participate in the planning and take more ownership of the development interventions.

Facilitating factors for A&Y programme:

-The comparative advantage of UNFPA as a strong advocate for SRHR helped leveraging resources and interests from the government and development partners, to draw more attention on the SRHR needs of adolescents and youth.

- Evidence from "Generation Breakthrough" phase one built strong grounds for scaling up of the project and its second phase where interventions have been expanded to 250 new schools. The Ministry of Education has also expressed their interest in introducing the GEMS curriculum and SRHR materials in 11,815 secondary schools countrywide.

- The Government has a good understanding of the importance of working with adolescents and youth and the importance of formulating youth-friendly policies in order to leverage the benefits of a 'demographic window of opportunity'.

- The organic structure of the population and heavy density is in fact acting as an impact multiplier; therefore SRHR campaigns can reach more people with minimum effort and less financial resource because of the closely knit community structure in Bangladesh.

Constraining Factors for A&Y programme:

- Limited financial resources for A&Y interventions resulted in a relatively small programme which has the potential for scaling up and would benefit the adolescents and youth of the country.

- The health sector in Bangladesh is characterized by its ineffective decentralization, inadequate infrastructure and equipment, prohibitive treatment charges, specific gaps in terms of female doctors and health workers, and poor sanitation facilities which make it more difficult for health facilities to be adolescent friendly.

- The recent trends in the radicalization of the youth population and the influence of fundamentalists groups is a constant threat for the development gains achieved in the last four decades.

- The lack for an efficient and truly inclusive youth development policy which acknowledges the different needs of indigenous youth, people with disabilities, the specific needs of vulnerable and marginalized youth populations from remote lands and excluded part of the society (tea gardens, haor, dalit communities, etc.) is a concern and their SRHR needs are yet to be prioritized.

4.2.3 GEWE: Effectiveness

Summary of findings: The gender component has been effectively contributing at both national and district levels to plan, coordinate and monitor strategies, policies and protocols to address GBV and harmful practices and taken steps to increase the availability of information and services on the matter. It has also sought to bring positive changes in gender norms through various initiatives. The targets of CPD/CPAP results indicators are in the process of being achieved albeit at a slow rate given initial problems such as getting TAPP approved and finding appropriate implementing partners in the Government. The planned activities (in both development and humanitarian sectors) are mostly in place or are in the process of completion according to work plans. There have been notable achievements and the effectiveness of many activities which have been recognized and socially accepted by relevant stakeholders.

Scope for improvement however remains as challenges, mainly with coordination of government agencies and capacitating all relevant stakeholders in the midst of frequent transfers and turnovers. UNFPA however possess facilitating potential through which more systematic hindrances to programme management such as image-building, synchronization between development and humanitarian sectors, and planning can be overcome.

In the development sector, the Gender component contributed to: (a) the setting up and operationalization of a national mechanism to plan, coordinate and monitor strategies, policies and protocols to address gender-based violence and harmful practices; (b) increased availability of information and services to prevent and address GBV and harmful practices (in both development and humanitarian settings); and (c) positive changes in gender norms, including intolerance of GBV in communities. The implementation took place through engaging the MoWCA, MoLE, and MoHFW, as well as law enforcement agencies, the private sector, media, CSOs, NGOs, and UN organizations.

The national mechanism to plan, coordinate and monitor strategies, policies and protocols to address GBV and harmful practices is in the process of being set up and in some cases are in place. Progress is taking place according to the annual work plan.[41] For example a National Protocol on Health Sector Response to GBV for health service providers who were trained on the protocol to support its implementation has been developed and approved by MOHFW. GBV has been mainstreamed into the Factory Inspection Checklist of the Department of Inspection for Factories and Establishments (DIFE), which has been approved by MoLE and currently being used in the existing training program of the Industrial Relations Institute. An exemplary breakthrough was the adoption and approval of an operational strategy to prevent and respond to GBV and gender discrimination in the workplace by MoLE. Police Stations were capacitated to provide GBV services to women and girls as per SOPs. Vulnerable populations including adults, children, people with specific needs and GBV survivors were empowered during the year and GBV interventions reached out to host community villages. Further achievements under GE are detailed in the Annex C.

Some of the interventions in the GEWE sector could not be covered due to the selection of sites where sufficient data for such programmes could not be gathered. Some interventions are in the process of being rolled out. A few examples of these are: working with men and boys to prevent GBV and harmful practices, implementing new development project on GBV prevention (adaptation of SASA) in Cox's Bazar (host community only) supported by GAC, integration of the VAW data in the crime management system operated by the Bangladesh police with a vision to roll out across the country, comprehensive analysis of existing GBV related laws to identify the loopholes and propose the possible recommendations for the policymakers for its necessary amendments in partnership with Action Aid Bangladesh and Law Commission, working with other UN Agencies like UN Women to enact a new legislation Sexual Harassment, and supporting the Ministry of Education to develop a guideline for Anti Sexual Harassment Committees in secondary and higher schools. CP9 is a short cycle (2 and half years) and programmes are still not mature enough to see results.

[41] UNDAF, Bangladesh UNDAF Annual Results Report (2017) and UNFPA Bangladesh Annual report 2017, 2018

Much of the achievements mentioned above have yet to reach all GBV stakeholders at District to the Union levels. Furthermore there is an inherent challenge in capacity building that through referral systems (multi sector GBV response which is a new initiative needing more time to be fully functional), are in place at district levels but in certain places operate in less than optimal functionality due to insufficient exposure of staff to training, frequent change in posting and quick turnover, as stated above.

WHDs (in police stations and court) show greater openness to women and child survivors but infrastructure is still constrained as there is perceived to be limited space for women's seating and toilet facilities in some places. Stakeholders felt that a critical mass of women in police force needed and needed to be pushed for with the authorities[42] (see example in good practices section). At the national level, awareness of key policy makers need continuing advocacy with the Government. It was also felt that timely completion of the project is often hampered as a result.[43] Community protection mechanisms like the NNPC has been activated but observations from the field reflected the need for further capacitating them in terms of evidence based data e.g. actual number and types of VAW data in the locality and nationally as well to make systematic decisions.

Though DWA is an IP and has the monitoring role over OCCs in the district and Upazila level, it was found[44] that GBV protection issues were weak in OCCs as survivor centric care is often compromised or not understood. Survivors in some places are received by male nurses and program officers. Although OCCs are not directly benefited by UNFPA programs it was observed that UNFPA as global leader of GBV can influence or give support in monitoring of OCCs in line with international standards and principles through advocacy with DWA. The launch of the ASTHA programme which has comprehensive capacity development intervention for health service providers including using OCC were steps taken by the UNFPA to address this gap. Additional data on GE Output Performance are available in Annex C-1.

GBV in Emergencies: *Effectiveness of Humanitarian Response*

The GBV preparedness content in emergencies related to natural disasters in all districts around the country including Cox's Bazaar has been established. The Gender Unit has country wide preparedness and response intervention and plays a key role for the inclusion of GBV in the SOD of MoDMR. During the field visits to the districts of Jamalpur and Patuakhali both flood prone and cyclone affected area, the team observed these mechanisms to be in place even at the Upazila level. In Cox's Bazaar, the humanitarian program that ensued in a mass scale was caused by a human-made disaster. UNFPA led GBV Sub sector humanitarian programs have made headway there as well. According to the Jan-June, 2019 ISCG situation report, it mentioned that GBV partners provided various training to a total of 176 GBV service providers and humanitarian staff on GBV core concepts, case management, GBV referral pathways and IASC guidelines for integrating GBV in humanitarian action.

Nineteen Women Support Groups have been established, one in each WFS, and 380 women have become empowered to proactively engage in leading sessions on GBV prevention and emergency referrals, as well as on the availability of SRH services in the respective facility. GBVIMS monitoring was conducted in 8 facilities in 4 camps (additional data on coverage is in Annex C-1). According to ISCG,

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[42] KII with stakeholders and IPs
[43] Interview with CO Gender Team and UNFPA IPs
[44] Observation from the field

unavailability of security actors, mental health in some camps as well as heavy justice procedure, impunity, fear of reprisals and stigma are among the main reasons leading survivors to decline services.

During field visits observations, stakeholders commented that the program could be further improved if adolescents and the elderly women in WFSs could be brought more into focus in relevant activities as they were usually neglected by their own family and social structures (FGDs with Rohingya women in WFS in Kutupalong). Girl Shine programme, discussed under A&Y section, was introduced by UNFPA in partnership with IRC. It was also felt by the evaluators that synchronization of the humanitarian and development sectors may contribute towards increased effectiveness.

Facilitating factors for Gender Programme: UNFPA is recognized and accepted as Global leader of GBV; UNFPA is leading GBV national level cluster and GBV sub sector (potential for cross learning); UNFPA follows clear international guidelines and standards; National policy relevance high in both development and humanitarian sectors; Existing official perception that UNFPA has core role to play in emergencies on SRHR and GBV issues; Good local partnership in GBV and field presence of the gender unit.

Constraining Factors for Gender Programme: Narrowly defined objectives of GBV and SRHR as perceived by various stakeholders and also in comparison with other UN Agencies and Difficulties of capacitating implementing partners: frequent change of staff/ postings.

4.2.4 Population Dynamics: Effectiveness

Population and Development (P&D) programme delivers on policy advocacy, data and knowledge creation and sharing, capacity enhancement, and maintains programme coherence by coordinating and supporting country team with policy and strategic oversight on emerging population issues. There is more room for PD unit to be engaged as a cross-cutting service provider with technical assistance within the country office. Following the theory of change established by CO, programme outputs are logically linked and contributed to in achieving the outcomes. Supporting evidence, with specific examples, is explained in Annex D-1. Assistance to humanitarian sector, in making data available for planning and decision making, is effective and timely, and continued to provide needed technical expertise. Engagement of strategic partners, specifically over the long-term, has contributed to the effectiveness of the programme.

Broader strategic issues such as where the National Population Council (NPC) is administratively housed and the limited use and recognition of P& D unit's overarching role may weaken the effectiveness and specifically the contribution that unit could offer in population and development policy and advocacy areas.

P&D unit supports GOB in three key areas: Population Data, Population Policy and Capacity Building of national institutes on data generation, analyses and dissemination to inform evidence-based planning, budgeting and monitoring and developing Knowledge Products on population development issues. P&D unit works very closely with key strategic partners: BBS, GED, Parliamentarians and Population Sciences Department of Dhaka University to achieve these outputs, which in turn contributes to the expected outcomes. UNFPA support to increase the commitment of policy makers and programme managers to advance the ICPD beyond 2014 and the 2030 Agenda for Sustainable Development has mainly been through these strategic partnerships.

UNFPA, with Bangladesh Parliament Secretariat (BPS) under the project “Strengthening Parliament’s Capacity in Population and Development Issues (SPCPD),” an Advocacy Plan was developed and completed in April 2019. SPCPD project includes, improving maternal health, ensuring safe delivery and FP; eliminating child marriage and preventing GBV; and Population Dynamics and youth development as three priority policy advocacy issues. Three Sub-committees were set up to strengthen advocacy efforts and these three policy advocacy issues for implementation during CP9.

Key achievements of the 3 Sub-committees of BAPPD during CP9 are: Bangladesh Association of Parliamentarians on Population and Development (BAPPD) in consultation with UNFPA drafted a Bill titled ‘**Maternal Health Protection Bill.’** With technical and financial support from UNFPA, the process to prepare the Bill entailed four consultation workshops at divisional and national levels and by organizing a policy dialogue to sensitize Hon'ble Members of Parliament (MPs), high-level Parliament Secretariat officials, concerned Ministries, Development Partners, academicians, NGOs, Civil Society, media and other relevant stakeholders to mobilize policy directions in support of formulating the said LAW.
The Bill is expected to contribute to reducing maternal mortality and morbidity in the country by ensuring emergency medical services, proper notification of maternal deaths and ensuring accountability of service providers and family members as well. Child Marriage Restraint Act is done and costed ECM action plan is in progress.

General Economics Division (GED) of Bangladesh Planning Commission developed the final draft M&E Framework based on several consultations to identify data sources of SDG indicators, to set multi-year targets and to map ministries responsible for the implementation of specific targets, aligned with 7th Five Year Plan (2016-2020). UNFPA, as an active member of the UN Data Group, played an important role to include UNFPA mandated indicators in the framework. UNFPA also provided technical support to GED through their meetings with UN Data Group and written comments to improve the framework. UNFPA is working with its government Implementation Partners to establish a comprehensive data collection and management mechanism to monitor and report on their relevant SDG indicators.

Workshop on SDG Indicators

A population expert group has been formed under GED with UNFPA support, in order to lead knowledge generation, sensitization and integration of population dynamics in government development programmes, specifically in national and sectoral plans. GED leads the policy level activities of the Government and has a coordination role among sectoral ministries and development partners regarding development issues. The Expert Group is comprised of 24 experts in population and development working in Bangladesh.

Population Data: Support to and achievements of BBS: Under the 9th CP, UNFPA has supported to develop the statistical system of BBS and implemented several activities that cut across NSDS[45]. Promotion of Government open data policy through the dissemination of micro-data (REDATAM), publication of the statistical report with population figures and GIS features (district ATLAS, disaster-prone ATLAS etc.), setting up of GIS Platform to coordinate national level GIS activities, harmonization of demographic surveys to promote official statistics, human resource development of BBS (participation of BBS officials in in-country and overseas training) etc. all are integral parts of NSDS that was implemented under CP9. With a functional GIS platform[46] in place, nine government agencies are using GIS for analyses of population data. Four databases (SRVS 2010; Economic Census 2013; MICS 2013; and HIES 2010) were uploaded and disseminated through REDATAM web portal that will also help facilitate mapping of inequalities in and demographic disparities in the country. Master Plan for 2021 census is supported by UNFPA and questionnaire finalization was done at the time of the evaluation, June, 2019). For the first time in the country, a multimodal data collection will be employed in 2021 census.

Census Questionnaire Finalization

BBS has been undergoing a restructuring process to make the statistical system more decentralised. Each of the 64 districts now has one statistical office. As the statistical offices were set up recently, staff deployment is not complete and has infrastructural and human resource constraints. Based on our observations during the field visits, and confirmed by national as well district officers, the overall capacity at district level is still weak.

Harmonization of major demographic surveys in the country: The Statistical Act 2013 that was passed in the Parliament gives full autonomy to BBS to produce and authenticate official statistics. BBS also endorsed BDHS as it provides data every three years following a different methodology. Considering the complexity and the lack of consistency in the demographic data collection process in Bangladesh, UNFPA has taken the initiative to harmonize all demographic data collection process in the country and has been advocating the Government and different data producing agencies since 2016. A positon paper on "Harmonization of major demographic surveys" was prepared by BBS with UNFPA support. However, evidence on application of this is lacking and there is more room for implementation of this concept.

Knowledge sharing is a key part of PD and is implemented through Workshops, Training Programmes, Policy Briefs, Media Reports, Publications, Research and Survey Reports and Documentaries. Digital bill board delivering key messages and data about population issues, reproductive and maternal health, adolescent and young people has been displayed inside the parliament to sensitize the parliamentarians. Most of the knowledge products under P&D have been used for policy dialogue and some have been published for wider use. P&D programme has contributed to knowledge products in GE, A&Y and SRHR. Table in Annex D provides examples of knowledge products and their application.

[45]BBS, with the technical and financial support of the World Bank had completed the National Strategy for the Development of Statistics (NSDS), a holistic approach covering the entire National Statistical System to make the data producer more responsive to users' needs and demands, and to focus on emerging issues like environment, gender etc. NSDS assisted the concept of 'Digital Bangladesh' providing huge volume of data.

[46]With CP9 support National population database– is accessible via web-based platform where Government and non-govt agencies are able to use GIS for population data analyses.

With UNFPA collaboration, for the first time a new module on maternal health morbidity was included in the MICS 2018-19 survey. This is to provide the proportion of pregnancies with eclampsia before and after childbirth, the proportion of pregnancies with antepartum and postpartum haemorrhage, and proportion of pregnancies with infection/sepsis during and after pregnancy. Several Capacity Development Interventions had been completed under CP9 that are directly linked to planned outputs and a list of these is available in Annex D. A list of training and the beneficiaries is also available in the annex. Due to the lack of human resources, evaluation of or follow up on these CD programs have not been done. However, Dhaka University has conducted their own evaluation of the training carried out by them. 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 (For details of PD performance, please refer to the Annexes D-1 to D-3).

PD Contribution in the Humanitarian Context:

- Small Area ATLAS of the disaster-prone six districts was developed with information related to available facilities where disaster-affected people can take shelter.
- A quick calculator was developed, with support from APRO, using Excel Spreadsheets to estimate demographic profiles of Rohingya refugees at the very early stage of the problem which has substantively been used for developing funding proposals and programme support.
- PD in collaboration with ICDDRB (an international NGO based at Dhaka) conducted a needs assessment of Rohingya population. This study provided a more precise estimate of different demographic parameters based on primary data. The study findings were widely used by programme colleagues and other agencies working for Rohingya population. This was among the first few comprehensive studies conducted among the Rohingya refugees to document their demographic profile. This study finding was disseminated among data focal persons of different departments working in CXB districts.
- Currently, the CXB team is undertaking a similar study using the same methodology, and UNFPA PD team is overseeing quality assurance of the study.
- PD has been providing technical support to the data focal persons at the CXB office; such as responding their queries, providing data from NSO (population data from census), age and sex disaggregated micro data etc.
- PD also provided data support to the CXB team to respond to the affected population due to a landslide that happened in 2017

Needs Assessment Survey among Rohingya population : Evident by feedback from the users of survey data indicated the usefulness of the assessment at that stage – being timely and only source of data to use for planning which had been very useful. UNFPA continues to support generation of data and development of survey methodology that are needed/required for planning services and logistics for the Rohingya populations.

UNFPA has contributed to improved and quality data availability and analyses on population, SRH, youth, GBV (and in the humanitarian context) evident by the population-based data that are accessible through web-based platforms, user friendly databases with UNFPA contribution. The capacity of national institutes increased to provide disaggregated data in a timely and user-friendly manner evident by the national statistical authorities producing evidence-based analyses on A&Y, SRH, and GBV in development and humanitarian settings. UNFPA-supported data and their analysis on population, SRH,

youth and GBV issues are being used in national and district-level policy making, planning and implementation. There is still a preference to rely more on BDHS data than data produced by BBS (SVRS and other surveys) perhaps due to the quality and reliability issue with BBS data based on the transparency and not being backed by any international organization. To make the system more effective and sustainable, the technical capacity of BBS could be strengthened and the independence should be given to BBS for enhanced transparency and data availability for public use (public access to data).

Facilitating Factors for Population and Development Programme: Long standing cordial relationship with IPs and the strategic selection of IPs, optimize results; UNFPA's special niche, acceptance and acknowledgement UNFPA's added value in the technical assistance by the IPs and flexibility in relation to the programme planning; UNFPA, over the CP cycles, has created a pool of resources within the country -Working closely with the champions in the parliament and engagement of high-level strategic partners.

Constraining Factors for Population and Development Programme: Financial resource constraints and the inability to commit long-term; Inadequate government planning capacity; Engagement of high-level strategic partners, while this facilitates the processes, at the same time, due to their high status scheduling of meetings and obtaining signatures for approval of key documents needed for program implementation and approval take a considerable time; In-house (UNFPA) technical capacity and HR constraints (this is expected to be addressed soon); Lack of flexibility related to financial transactions; Lack of flexibility with government approval if any changes are needed to the programme- e.g. TAPP[47]; and Population issues not factored fully in the government development planning processes.

4.3 Answers to evaluation questions on Efficiency

***EQ 4**: To what extent has UNFPA made good use of its human, financial and administrative resources, and used an appropriate combination of tools and to demonstrate accountability to stakeholders and pursue the achievement of the outcomes defined in the 9th country programme in a timely manner?*

4.3.1 Sexual and Reproductive Health: Efficiency

Summary of findings:

- The large influx of Rohingya refugees since September 2017 put a considerable stress on the Human Resources of the CO's development programme, even after installation of a surge team in Cox's Bazar.
- UNFPA has been making use of long term partnership and trusted relations with DGHS, DGFP and DGNM while programme implementation has, moreover, been supported through strong partnerships with non-governmental agencies, and with commitments based on yearly work plans and country programme periods. Financial bureaucracy of UNFPA was at times criticized by partners as cumbersome.
- UNFPA has continued to engage with donors in longer term partnerships, enhancing mobilized resources with donor funding increasingly important in humanitarian as well as development programming, due to a sharp decline in UNFPA's regular resources.
- A comprehensive monitoring system has been put into place. The database developed appears to offer further opportunities for data analysis, in order to provide evidence on what works and what does not and to enhance in this way the evidence base of the present as well as the next programme cycle.

- SRHR component has been supported by a team that is highly regarded as committed and technically

[47] UNFPA revises its priorities annually and the technical project proposal where activities are approved is a static document. Limited flexibility in the technical project proposal makes it difficult to carry out an activity if there is an emerging need.

competent; HR realignment and delays in is implementation resulted in various positions of the SRHR team remaining vacant at the end of 2018 and the start of 2019, which affected programming.
- Through its engagement in the HPNSDP (Health SWAp) the SRHR component of the programme has been able to avoid the delay that occurred in other components of the programme in terms of TAPP approvals.

Partnerships:

UNFPA worked with a large number of partners in the implementation of the SRHR programme. A total of 21 partners were involved in the programme, 14 in the development programme and 7 in the humanitarian programme. Amongst these 21 partners, three concerned government agencies, another three concerned universities and research institutes and the remainder of 15 concerned different types of civil society organizations.

The relative focus on MOHFW and its directorates general is evidenced by the three DGs of MOHFW together spending 41 percent of the development budget. Second largest partner in terms of the development budget is SCI, who is running large part of the midwifery mentoring programme with 20 percent of the development budget.[48] Other substantial parts of the budget are addressed at development of midwifery faculty with Dalarna University, behavior change communication through BBC Media Action and support to tea garden workers in Moulvibazar through CIRBP. In the humanitarian programme most of the resources go to partners that implement part of the programme, with fewer resources for partners that conduct research and assessments and for the Bandhu Social Welfare Society, focused at addressing SRHR needs and HIV services for boys, men and transgender of host communities and refugees in Cox's Bazar. UNFPA staff has been located part-time in offices within the various DGs, enabling a close working relationship with GOB staff. This has provided UNFPA with a close working relationship with government, with these positions appreciated by the various DG staff. Part of the role of these staff members is to provide hands-on technical support to staff of the DG, supporting the DG in its role as implementing partner to the UNFPA support programme.

Monitoring and Reporting in the SRHR Outcome Area

An extensive monitoring system has been put into place, underpinned by a complex results framework for each of the three components of the SRHR outcome area with a total of over 90 indicators. A set of tools was developed to assess progress at the level of medical college hospitals and district and upazila level health facilities. These tools were developed during the first quarter of 2017. Baseline data was collected in each of the 19 focus district at the level of district hospitals, upazila health complexes and medical college hospitals in the first half of 2017. Checklists for CEMONC, UH&FWC and Community clinics and others were added in 2018. For an overview of all

Monitoring forms used for SRHR related monitoring data quarterly

- Checklist for a monitoring visit to a Service Delivery Points
- Checklist for a monitoring visit to a Medical College Hospital
- Checklist for a monitoring visit to a Upazila Health Complex
- Checklist for a monitoring visit to a District Hospital
- Checklist for CEMONC facilities (UHCs and MCWCs)
- Checklist for a monitoring visit to an Union Health & Family Welfare Center
- Checklist for data collection from a Community Clinic
- Checklist for monitoring competencies of Midwives to provide midwife-lead continuum of care
- EMONC Signal Functions and other essential services
- Monitoring of MISP implementation
- Monitoring SRHR working group
- Monitoring integrated SRH services brothels
- Monitoring integrated SRH drop in centers
- Checklist for monitoring implementation of MPDSR
- Integrated SRH Services SRH/ GBV Client Satisfaction Survey

[48] Calculations based on NEX execution only. Source: Annual Work Plans of Implementing Partners 2017-2019.

forms see box "Monitoring forms used for SRHR related monitoring data quarterly."
Data gathering at sub-national level proved challenging with lack of human resources. This changed with the establishment of a dedicated national level M&E unit and the recruitment of field staff in targeted districts. A total of twelve programme officers monitored programme progress on a quarterly basis, covering all of the 19 UNFPA focus districts. Data gathering was initially done through the use of paper forms, but more recently data are being entered electronically making use of smart phones and collected centrally at country level. This is providing a large set of monitoring data on all the components of the SRHR outcome area. Monitoring tools have also been developed and used in the other outcome areas of the country programme. Monitoring data have been used in reporting and have started to be used in informing programme management.

Implementing partners report to UNFPA on a quarterly basis. These reports are focused on activities and resource use with usually no analytical approach in terms of results achieved. UNFPA reports to donors on a regular basis, which reports are much focused on the quantitative details of indicators from the results framework. Also here analysis of the data presented has been limited.

Also in UNFPA's humanitarian response the country office makes use of a monitoring system, including assessment of inputs, service utilization and quality of services provided, with the monitoring system including the setup of a database, training to IPs on reporting and data quality checks on the ground. Monitoring data gathered was used for situation reports, donor reports, situation updates to UNFPA APRO and UNFPA HQ, informing response planning and resource mobilization.

Constraining Factors: The national GOB budget for health in 2019 was only 1.2 percent of the total Government budget. Though higher than 0.9 percent in 2018 it is still too low with much of the amount going to salaries with less budget left for implementation of Government programmes; Several partners make note of short term planning, in development programming as well as in humanitarian response with the need for a longer term vision on the partnerships identified as important rather than an activity oriented approach; and Each of the three DGs have their own MIS system with limited coordination

Facilitating factors for Efficiency in the <u>Humanitarian Response:</u> UNFPA APRO provided support to humanitarian response in Bangladesh through support to proposal development and facilitating access to funding, including UNFPA headquarters funding and the UN Central Emergency Response Fund (CERF); Use was made of the fast track system in terms of procurement of items, though this still took considerable time, it saved time in comparison with the normal procurement arrangements; and APRO sent staff to the country office in the early onset of the emergency, in order to enhance human resources and for procurement purposes
Constraining factors: Procurement process in fast track still took 2 months of time.

4.3.2 Adolescents and Youth Efficiency

Summary of findings:
According to partners, technical support and financial resources allocated for programme interventions from UNFPA have been reported as satisfactory. Most of the A&Y interventions of CP9 are being efficiently implemented by partner agencies for both development and humanitarian programmes. Strategy to lobby with the relevant government departments and receive commitments

to leverage more resources from the government to expand Generation Breakthrough's GEMs curriculum and SRHR materials to be rolled out in 11,815 secondary schools seems to be successful.

UNFPA has been collaborating efficiently with other UN agencies to implement the Global Programme to End Child Marriage and successfully advocated with the government to formulate the Child Marriage Restraint Act, the National Plan of Action to End Child Marriage and the National Adolescent Health Strategy. UNFPA took the lead in developing the new Adolescent Health Strategy where resource allocation to address ASRH is a key focus. This strategy document also points to a strong UN inter-agency collaboration where UNFPA, UNICEF and WHO worked together to support the Ministry of Health and Family Welfare. UNFPA's comparative advantage is highly appreciated by partners and acceptance among the stakeholders as an advocate for the ASRHR agenda, Life Skills Education, knowledge based advocacy is reported as strong.

The A&Y programme implementation suffered significantly from a slow start in the first year and second year for some Government Implementing Partners (DSHE, MoWCA), mainly due to the delay of TAPP approval process as described elsewhere earlier. ECM programme started in mid-2017 and Generation Breakthrough programme waited till latter part of 2018 until the evaluation was conducted. The A&Y planned interventions for CP9 have been efficiently facilitating the government to draw adequate attention towards the development needs of adolescents as vulnerable group of population in terms of their unmet needs for sexual and reproductive health issues. UNFPA took the lead in developing the new Adolescent Health Strategy where resource allocation to address ASRH is a key focus. This strategy document also points to a strong UN inter-agency collaboration where UNFPA, UNICEF and WHO worked together to support the Ministry of Health and Family Welfare. Technical support and financial resources allocated for programme interventions as stipulated in CP9 by UNFPA have been reported as satisfactory. However, partners expressed that there is a need to expand the A&Y programme interventions for which more resources would have been required. Despite late start, most of the A&Y interventions of CP9 are being efficiently implemented by partner agencies for both development and humanitarian programmes. However, due to challenges with approval process, some of the informational materials are still in storage - being unable to distribute to the intended beneficiaries.

Information materials still in storage

Joint programme with UNICEF ('Global Programme to Accelerate Action to End Child Marriage'), joint implementation of "Improving maternal, sexual, and reproductive health and rights" with SRH unit, and collaboration with GEWE team in integrating adolescent and youth interventions under ASTHA "Strengthening Access to Multi-sectoral Public Services for GBV Survivors in Bangladesh" are some examples of efforts to enhance efficiency as well as integrating youth as cross-cutting. The collaboration with other agencies, UNFPA has been able to manage and utilize the funds efficiently, as noted from the documents and discussions.

After the Rohingya influx in August 2017, UNFPA GBV programme interventions have been promptly launched emergency support for the GBV survivors in the refugee camp and gradually extended its

support for the host communities, while A&Y Unit joined hands with GEWE to integrate adolescent focused SRHR and GBV interventions in the later part of 2018. The 'Strengthening Sexual and Reproductive Health and Rights and Gender-Based Violence Services' programme in Coxs Bazar is being jointly implemented by the SRH, gender and A&Y Units with 180K (2019-2020) allocation for the adolescent-focused interventions under the project.

Factors facilitating and constraining factors are same as mentioned under the effectiveness.

4.3.3 Gender Equality: Efficiency

Summary of findings: The gender component of the budget has been constrained in the 9th CP due to heavy focus on humanitarian response. Manpower and human resources has also been under strain. Bureaucratic red tape and also the challenge of timely access to Government stakeholders has been the cause of delay to project activities. But UNFPA had adapted its activities to meet the programme objectives and timeline. Timely completion is a challenge in the humanitarian sector as the staff is overstretched having to receive too many visitors, mobilize resources, and preparations donor reports. Reporting to donors was done in a regular manner through coordination meetings and following up of decisions of such meetings.

The budget for GEWE for the 9th Country Programme was (2017 to 2020) was proposed to be 8.1 million USD, with 7.6 from regular sources and 0.5 million USD from other resources.[49] The total constitutes 15.40 % of the total assistance but 28.9 % of regular sources (2nd in position to SRHR which was 35.74%). In the total budget GEWE is positioned in third place next to SRHR and A&Y. The country office gender team felt that considering the fact that UNFPA is a global leader of GBV, the gender programme had insufficient allocations of funds and the IPs working on GBV held the same view. The Budget and Expenditure Analysis based on 2017 and 2018 shows 3% of total expenditure in Output 3.1 on a national mechanism operationalized to plan coordinate and monitor strategies, policies and protocols to address gender-based violence and harmful practices. It showed 86% of expenditure in Output 3.2 related to increased availability of information and services to prevent and address gender based violence and harmful practices both in development and humanitarian settings and 11% for Output 3, which was related to positive change in gender norms including intolerance of GBV in communities. The expenditure analysis of 2019 is yet to be done.

The above expenditures can be read within the context of the situational response arising from the context of Rohingya influx into Bangladesh 2017 and also other natural disasters like landslides in Chittagong Hill Tracts which is registered as a large-scale over expenditure in Output 3. The comparatively low rate of expenditure in Output 1 may be attributed to delays in approval of project by the Government, change of implementing partners for better facilitation of the project objectives, for example from Ministry of Labour and Employment to Department of Inspection of Factory and Establishment.[50] This change was perceived to be beneficial and more appropriate as the Ministry dealt with policy issues whereas the DIFE was better positioned to implement. Former partners also mentioned that the objectives of the project could be better handled if alternative institutions from the

[49] Proposed Indicative UNFPA assistance, UNFPA Country programme document, 2016
[50] KII with Gender team.

private sector like the BGMEA could have become implementing partners as well.[51] Despite such constraints, the programme had adapted its activities so that it achieves completion within the country programme period.

GE in Humanitarian Setting: The Rohingya humanitarian crisis during the CP9 period also put strain on skilled manpower and human resources as initially the CO had to coordinate GBV prevention and response in both humanitarian as well as development sectors. Currently a UNFPA sub-office is in place in Cox's Bazar and CO directly managed both progarmme and budget until Dec 2018 but now CXB is managing the programme and the budget is still managed by CO.
Timely completion is a challenge in the humanitarian sector as the staff is overstretched due to attending too many visitors, and meetings and the gigantic task of multiple fund management in a humanitarian crisis of enormous proportion. This tended to leave little space for proper planning and organization of activities as was evident in some of the issues being discussed in the gender sub-sector meeting in Cox's Bazaar. Similar problems are also apparent at the CO level.[52] Apparent from the multitude of the crisis in CXB, it was a huge challenge for CO staff which had hampered the development project implementation.

In terms of accountability, UNFPA demonstrated adequate sensitivity to validation of programmatic inputs by the beneficiaries, such as the components and standardization of the dignity kits, GBV case management and psycho-social support and referral, including the direct cost of referral. Reporting to donors had been done in a regular manner through coordination meetings and decisions of such meetings were followed up, as observed in the field records and interviews with field staff.

Facilitating factors: UNFPA response in the humanitarian sector received attention of donors due to the Rohingya influx; Easy access to Government officials in development sector projects enables advocacy
Constraining Factors: Too many visits, meetings overstretched staff; Bureaucratic red tape in processing documents for getting permission to work in the field ; and Shortage of funding and manpower.

[51] KII with IPs and private sector institutions
[52] Field observations

4.3.4 Population Dynamics: Efficiency

Summary of findings:

-Engagement of strategic partners, without establishing any parallel structures or mechanisms to implement the PD programme, high programme relevancy, and the continuity of country programmes over several cycles with the same partners contributed to the programme efficiency. However, despite input for capacity development, one UNFPA paid staff is allocated for coordination, monitoring and reporting responsibilities. This, in the short-term may increase efficiency of the implementation; it may not be a sustainable arrangement.

-Delays in the fund approval mechanism seem to have affected the efficiency and effectiveness of the programme at the start. While the engagement of high profile IPs is efficient, their busy schedules and conflicting priorities affect both efficiency and effectiveness. However, given the budgetary as well as technical capacity and human resource limitations, UNFPA has made good use of its human, financial and administrative resources to achieve the outputs that are clearly linked to achieving the planned outcomes. Despite the short duration of CP9, the planned results are achieved efficiently and effectively.

-Capacities of BBS, GED, and academic institutions strengthened during CP9. As for the current Census preparation process, the technical capacity built during the previous census and some of the logistical arrangements established are still available which enhance the efficiency.

UNFPA collaborates with: a) the GED, Planning Commission, Ministry of Planning, for national integration of PD into national and sector plans; b) BPS (Bangladesh Parliament Secretariat) to build political commitment of MPs to country's development policies, plans and budget that takes into account the population dynamics, reproductive health and gender concerns based on evidence and national level statistics; c) Population Sciences Department (DPS), University of Dhaka for human resource development and research on P&D; and d) Bangladesh Bureau of Statistics (BBS) to carry out population Census, generate age, sex and location disaggregated official statistics/data, monitoring of vital events, generate data for SDG monitoring and reporting and strengthening GIS. Collaborative work had made PD programme produce outputs efficiently and effectively, contributing to the expected outcomes, as evident from the results (see under Effectiveness and Annex D)

Policy advocacy work aims to strengthen the capacity to strategically formulate and monitor implementation of policies and legislations. Collaboration with GED is intended to increase capacity of GED to integrate population and gender equality concerns including SRHR, A&Y in development planning and to incorporate emerging issues into national plans and policies.

PD IPs are strategic partners and the CP outcomes and outputs are very much in line with partner institutions' needs and priorities, thus both the effectiveness and efficiency are increased. As such the selection strategy of implementing partners (IPs) is very efficient and effective.

However, due to the high status/profile of some key members, at times, the communication has been delayed due to internal processes and protocol issues (for signing documents to obtain approval or scheduling meetings)-specifically with the parliamentarians, thus reducing both the efficiency and effectiveness due to unexpected delays and postponement or cancellation of planned activities.

The approval process of the technical assistance project proposals (TAPP)[53], affected the PD interventions in 2017. Frequent changes of government staff engaged in the UNFPA supported interventions also caused some inefficiency due to unfamiliarity of the interventions. The new staff has to be trained or oriented every time staff rotation took place.

Based on key informants' input, long delays in obtaining/transferring funds for the Census had been experienced during CP8. A no cost extension had to be sought and the funds that had accumulated (government funds were used to do some activities in the meantime during delayed period) were used to purchase equipment needed thus saving money during CP9 for Census activities.

4.4 Answers to evaluation questions on Sustainability

***EQ 5**: In what ways has UNFPA been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to address the challenges to ensure ownership and the durability of effects?*

4.4.1 Sexual and Reproductive Health: Sustainability

Summary of findings:

-The support to the capacity building aspects of midwifery as a profession made use of a systemic approach, with the development of faculty, including Bachelor, Master and PhD components, which have been incorporated in the midwifery and nursing colleges and one of the universities in Bangladesh.

-First two batches of Registered Midwives have been posted, though the same is unclear for the third batch.

-UNFPA support to the BMS has so far created a viable means to enhance midwifery in the context of Bangladesh.

-In terms of targeting at sub-national level use was made of piloting and service provision approaches. Though this was relevant in the context concerned, the opportunities for scaling up and sustainability of results of each of these approaches remained unclear.

-The combined support of policy level engagement and institutional capacity development in terms of policy implementation has resulted in the use of a systemic approach, exemplified in the MNH part of the programme.

In order to develop capacities of midwives UNFPA did not resort to direct support to training of midwives, but instead focused on the development of the education system for midwives, including a curriculum as well as opportunities for Bachelor, Master and PhD level studies. While the Bachelor degree was meant to result in trained registered midwives, the Master's degree was meant for teachers and the midwifery colleges. The PhD programme is adding a research component on midwifery related issues. Each of these components has been embedded in the regular Bangladesh organizational structure. The faculty is incorporated in the Nursing and Midwifery colleges while the PhD component is aimed to be part of the Dhaka University.

[53] The approval process for the technical project proposal is multi-tiered sometimes causing nearly one ear delay and this happens almost every year in the beginning of the CP cycle.

The first batches of midwives that have passed their exams successfully, have been posted in health facilities as regular staff members of DGNM, though with some delay. This means that they have become part of the regular staff of the MOHFW and thus incorporated in the human resources of the directorate. There have also been delays in the same for the third batch of registered midwives, with a need to monitor posting in order to ensure results of the programme are sustainable.

In order to enhance the profession of midwives in Bangladesh, UNFPA supported the BMS as a professional association. With a newly elected leadership and a growing membership of midwives, the BMS has substantial potential as a sustained means to enhance the position of midwives in the Bangladesh context.

In previous programme periods UNFPA as well as other development organizations have supported the development of capacities of skilled births attendants which were recruited directly by UNFPA as well as other supporting partners. While the skilled birth attendants were meant to be incorporated into the regular human resource base of the MOHFW, this did not happen in practice and after UNFPA and other agencies stopped paying for skilled birth attendants, they lost their main income generating opportunity. This example shows that one needs to be careful with direct payments to health professionals as they may not end up as regular staff in the Bangladesh health system. There are some instances in the present programme of payment of midwives stationed in project level initiatives in the tea gardens in Moulvibazar. Sustainability of these positions is yet to be guaranteed.

The allocation of staff within the various DGs of MOHFW has the risk of filling gaps and replacing capacity instead of providing technical support and enhancing capacities, something which would not be very sustainable in the longer run. The country office will need a plan in terms of the period for which this type of support will be continued, and what will be the point in terms of capacity development and programme implementation that such an arrangement will no longer be required.

Facilitating factor: The systemic approach applied by UNFPA in the midwifery programme.

Constraining factor: Taking up the human resource and financial costs required to sustain results in the longer term is constrained by the relative low amount of government resources spent on health.[54]

4.4.2 Adolescents & Youth: Sustainability

Summary of findings: UNFPA has been collaborating with the government to sustain programme results in the long run. For example, the A&Y programme partnered with the National Curriculum and Textbook Board to strengthen Life Skills Education in secondary schools and madrasas which, by dint of the nature of the work, will be sustained through mainstreaming LSE in the government's skills programmes. In addition, the policy and strategies developed with support from the A&Y programme of UNFPA will continue to sustain UNFPA's efforts to ensure that A&Y issues are given the focus it requires.

[54]This issue is also referred to in the 2018 annual review of the 4th Health Population and Nutrition Sector Programme (HPNSP) 2017-2022.

UNFPA has been collaborating with the government to sustain programme results in the long run. For example, the A&Y programme partnered with the National Curriculum and Textbook Board to strengthen Life Skills Education in secondary schools and madrasas which, by dint of the nature of the work, will be sustained through mainstreaming LSE in the government's skills programmes. In addition, the policy and strategies developed with support from the A&Y programme of UNFPA will continue to sustain the UNFPA's efforts to ensure that A&Y issues are given the focus it requires. The multimedia based ASRHR content and learning modules for schools and madrassas will continue to be used by the secondary schools and madrasahs which will also sustain the results of A&Y programme. As a result of strong advocacy and discussion, the Government is considering the possibility of mainstreaming health education, targeting adolescents and youth in schools. Evidence from the first phase of Generation Breakthrough built strong grounds for scaling up of the project modality into 250 new schools, under the second phase of the project. The Ministry of Education has also expressed their interest in introducing the GEMS curriculum and SRHR materials in 11,815 secondary schools countrywide.

4.4.3 Gender Equality: Sustainability

Summary of findings: Capacity building of IPs as outlined in work plans have been undertaken in both humanitarian and development sectors. A sense of ownership is growing. Strengthening of existing institutions in the development sector is considered important for sustainability. In the humanitarian sector, the extension of the planning horizon beyond the annual framework can offer sustainability.

Evident from the key informant interviews and field observations, due to frequent transfers, for example in the police women's help desk and quick turnover of staff, in the Rohingya response, sustainability of the programme was hampered. One officer pointed out, *"When we receive training as a police, we usually have quarterly refresher courses on how to handle firearms, but in the case of GBV prevention there are no such refresher courses. Hence it's not easily brought to our minds in the discharge of our duties!"* Refresher courses have been found to be inadequate as per our field information, including irregular attendance by the intended trainees. Many IPs who had started only a year ago, felt they needed an extension in the next programme cycle in order to strengthen their work contribution. Beneficiaries also felt the same.[55]

Women's Help Desk

But police officers running WHDs felt they could continue the work even in the case of transfers because the work itself was useful to people so the logic for its continuation would remain.[56] Resonating this, one woman police officer said "*Even if I am transferred to a station where there is no provision of a women's help desk, I will persuade my OC there to give me all the files related to complaints of women and children so that I can use the same experience that I have gained here."* Another officer said, *"It did not matter if the project ends, the needs and demands of the women who benefitted from this engagement will persist to ask for a system to meet those demands."* An important observation at the district level

[55] FGDs with beneficiaries

[56] KII interviews

was that engagement of a key player was missing in the coordination of activities supported by UNFPA. Feedback from KIIs, some staff of UNDP and IPs was about the key role that is supposed to be played by the District Commissioner in coordinating and supervising all activities in the district. Though this is an important role, it seems to be missing and DC office needs to be kept in the loop for the sustainability of all the projects.

Specifically in the Rohingya response programme, it was felt that strengthening of the development sector in the adjacent host community will help to sustain the humanitarian preparedness of the region. A senior Government official said, *"It is high time that we move beyond annual framework – SRHR and GBV is a core issue of refugees and hosts alike and hence will be sustained through its importance."*

Facilitating Factors: GBV is recognized as a core issue nationally; UNFPA's Programmes have included both development and humanitarian sectors; and UNFPA developed a partnership with a national NGO to address GBViE in 22 disaster prone districts.
Constraining factors: Frequent transfers and turnovers; Short term planning is inimical to sustainability; and Non-engagement of the DC as a key player in the district level.

4.4.4 Population Dynamics: Sustainability

Summary of findings: By design and mode of operation, PD interventions have a high level of national ownership and high relevance to the country priorities and national development strategies thus contributing to necessary conditions for sustainability. Engagement of strategic partners and the country office (CO) role as a catalyst rather than an implementer, there is high prospects for sustainability.
The Population Science Department (PSD) of Dhaka University, currently operating as a centre of excellence, is able to and has the technical capacity to provide high quality research papers, surveys and data. The department produces graduates and functions as a leading demographic institute. The impact of the UNFPA investments could be seen and there is enough evidence that the department can sustain its technical quality however, financial sustainability is still not fully realized.
Capacity of IPs have been enhanced to generate population data and these data are used by key decision makers for policy making and planning and programming as evident by 7th FYP and the proposed draft 8th FYP. Capacities of BBS, GED, and academic institutions are strengthened during project period and evidence shows the financial sustainability to carry on with the work. However, technical assistance is requested for some more time. While clear exit strategies are not documented, the expectation of the IPs is for technical assistance for capacity building for specific identified areas of expertise.

With building capacity of key individuals and institutions and playing a catalytic role rather than that of an implementer, most of the PD interventions are planned to be sustainable. The government expectation is technical support rather than financial support from UNFPA. UNFPA's mode of operation through joint planning and resource sharing with implementing partners enhances national ownership and sustainability. However, an area of concern is the continuing engagement of CO supported consultant to play IP role mainly due to the lack of capacity within the IP institutions. Technical capacity development of academic institutions such as Dhaka University is promising. However, some financial support for capacity development interventions would be needed until the academic institution have

enough funds of their own to carry out the work. A successful story is that a key IP Dhaka University could now generate funds by undertaking quality research and surveys for other agencies, including UNFPA, and may be able to generate adequate funds to sustain the centre.

With regard to other IPs, a few examples of likelihood of sustainability can be cited as the work of the sub-committees[57] in 20 districts where capacity and awareness of community, student committees; other stakeholders including marriage registrars, social and religious leaders were built to strengthen the social movement against child marriage and reduced maternal mortality. Building the capacity of locally elected public representatives and organizing motivational campaigns and strengthening monitoring systems, the interventions had ensured the local ownership. Some local administration had declared child marriage free upazilas and districts due to these efforts and this message is spread in other upazilas where no such campaigns are active.

Regarding demographic dividend (DD), while the need to reap the benefits of the demographic window of opportunity is widely discussed, a clear action plan to achieve DD is not available and the relevant departments have not made a commitment to sustain the work plan. There are no methodologies available to measure the benefits of DD. An innovative methodology on application of National Transfer Accounts" that focuses on revealing the trends and patterns of changes in age structure of Bangladesh population to enable appropriate investments and policies had to be stopped due to lack of funding. Though this training would have enhanced the capacity of the relevant staff, this training was given for a limited number only and further sessions had to be cancelled.

Facilitating factors: Working with the same strategic partners for more than one CP cycle; continued technical assistance; high relevance to the country's needs identified by the strategic partners; engagement of experts, think tanks, motivated politicians, and dedicated CO staff.

Constraining Factors: Shrinking budget from UNFPA side, frequent HR changes on partner side, vacant position for P&D unit (effectiveness issue as well) Chief, under-utilization or the lack of recognition of the lead role that PD plays in the interlinkages of the development, relatively lesser importance given to PD within the overall CP may weaken the central glue that PD provides UNFPA in its policy advocacy role.

<u>Unintended Effects as a result of CP9:</u>

One example is from the police dedicated to following up on GBV cases. During a search related to GBV cases, the police were able to identify many other crimes (apart from GBV) and those engaged in crimes at village level. The police was able to address the issues to maintain the peace and security of these relevant villages to some extent.

Work on stopping child marriage in targeted areas had spread to neighbouring areas which are not CP target areas. Feedback from the community, community leaders and implementing partners was that in these areas the child marriages are getting reduced even without any interventions.

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[57] Three Sub-committees are set up to strengthen advocacy efforts for successfully implementation of i) Improving maternal health, ensuring safe delivery and FP; ii) Eliminating child marriage and preventing GBV; and iii) Population Dynamics and youth development as three priority policy advocacy issues.

Lessons learned:

For sustainability and effectiveness, certain interventions need to have a longer maturity period that go beyond one CP cycle. Identification of strategic partners and aligning the work with the country priorities and needs, and focus on institutional capacity building produces better and long-lasting results.

By identifying key development issues that are within the UNFPA mandate and to lobby for addressing these jointly with other relevant UN agencies that have similar interests, UNFPA would be able to reap the benefits in a more cost effective and efficient way, than working independently on these issues. Some of these key development issues may not necessarily be in the interest of the government, but issues that matter to the concerned groups of people, especially vulnerable and marginalized groups.

4.5 Answer to evaluation question on UNCT Coordination

EQ6: UNCT Coordination: *To what extent did the UNFPA country office contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities / seeking synergies) within the United Nations system?*

Summary of findings: Participating in several working groups, UNFPA has played a key coordinating role and has maintained its strong presence in policy and key decision functions related to UNFPA's mandate. UNFPA's corporate strengths are well recognized and by other UN members for the contribution in improving the UN Country Team (UNCT) coordination mechanism. UNFPA has used its comparative advantage, taking the lead in advocating sensitive issues on human rights, ASRH, GBV, FP and HIV. However, there is room for improvement in advancing issues related to human rights and ASRH. UNFPA has been a knowledge broker and partner in successfully bridging and facilitating various players engaged in the development field.

UNFPA has played a coordinating role either as chair or co-chair in several groups, for example, as UNDAF Programme Management Team Co-Chair (UNDP as Co-Chair), UNDAF Outcome 3 Co-Chair (ILO is Co-Convener), Gender Equality Theme Group Co-Chair (UN Women is Co-Chair), Adolescents and Youth Theme Group Chair in 2017, UNDAF Data Group Co-Chair (UNICEF as Chair), UNDAF M and E group Chair and Youth Conflict Resolution and Peace Building Working Group Chair. Participating as a member in 17 working groups, UNFPA also actively represents, as Chair or Co-Chair in 4 groups in Cox's Bazar and has taken leadership of the SRH part of the health sector response in Cox's Bazar in close coordination with UNHCR, WHO and other stakeholders. UNFPA leads the RH working group under the health cluster, working jointly with UNICEF and WHO, the two agencies that share common interests in SRHR. UNFPA has positioned itself well based on its mandated areas and technical capacities. Attached list (Annex F) provides evidence of the extent to which UNFPA coordinates with UNCT.

4.6 Answer to evaluation questions on coordination with other partners

EQ7: *To what extent has the CO established, maintained and leveraged different types of partnerships to utilize UNFPA's comparative strength to achieve the outputs and outcomes of the 9th country programme?*

Summary of findings: UNFPA has been working with government and non-government partners

(about 38 in total) for CP9 implementation. The strategic partnerships established with the government has produced more sustainable results, though in some instances there is slow progress. However, in all partnerships UNFPA has been able to capitalize on the comparative strengths the agency brings in. Under the auspices of the Development Partners Consortium and the Health Local Consultative Group in Dhaka, UNFPA actively collaborates with UN agencies and others in ensuring synergies and avoiding duplication. Delivering results under four programme outcomes, over the past two and half years which this evaluation covered, each programme has identified the strengths of partners to maximize UNFPA's comparative advantage, both in the development as well as humanitarian setting, as discussed under several sections elsewhere in the report. With specific to GBV in humanitarian setting, UNFPA has established strong links with other national clusters to ensure the integration of IASC (Inter-Agency Standing Committee) GBV Guidelines into their programming. A key success was UNFPA's work with the Joint Needs Assessment Working Group, which has led to better mainstreaming of GBV issues into the assessment tools, and a commitment to include GBV in assessor training.

The A&Y team have been effectively coordinating with other UN agencies and Donors through Cox's Bazaar Emergency Office, as well as the humanitarian programme partners, sub clusters coordination groups for advocating gender equality, prevention of violence against women and girls, adolescent sexual and reproductive health rights issues among the adolescent girls and boys as well as the Rohingya communities in Cox's Bazar camp settings. The Youth Working Group, under the Education Sector is co-chaired by UNFPA.

UNFPA coordinated with development partners and other UN agencies to provide technical support to government and enacted progressive laws and policies to protect and ensure the rights of women and young people. Although greater emphasis has been placed on the importance of actualizing the full potential of young people in the country there still are many remaining challenges, as recognized in the 7th five-year plan. Joint work with UN agencies also forms part of CP9.

The national level GBV cluster is co-led by MoWCA and UNFPA. UNFPA is a key player and active member of LCG WAGE which is also a coordinating body. In addition UNFPA is the co-lead of Gender Equality Theme Group (GETG) of UNSDF, lead of GBV sub sector in Cox's Bazaar. The platforms together have contributed both to the visibility and advocacy strength of UNFPA with GoB and other UN Agencies on GBV issues.

In general, programme achievements can be contributed to the strong partnerships, mainly strategic partnerships, UNFPA's mode of operation in collaboration and consultation with the government and other key partners, being relevant to the country needs, UNFPA mandate and beneficiary needs.

4.7 Coordination (plus coverage, coherence and connectedness) in Humanitarian Setting

EQ 8: *To what extent are UNFPA interventions and approaches to addressing SRHR, GBV and harmful practices in humanitarian settings in line with the principles of coverage, coherence and connectedness and in which ways have they been coordinated with other agencies and stakeholders.*

Summary of findings: UNFPA coordination and positioning in humanitarian context in Cox's Bazar and other Disaster prone areas:

- UNFPA has well positioned itself in humanitarian setting based on its mandated areas and technical capacities

- UNFPA lead of the SRH working group under the health cluster and lead of the GBV cluster as well as chair of the newly established GBV sector for the Rohingya refugees
- UNFPA's comparative advantage in humanitarian settings has been strongly appreciated by the donors and partners. Acceptance among the stakeholders as a strong advocate for the adolescent SRHR agenda, gender equality and prevention of violence against women agendas have been highlighted, since the A&Y team have been successful to integrate ASRH messages and adolescent SRH content into the GBV programme and health programme interventions.
-*C*overage in humanitarian setting is already discussed under effectiveness section and additional details are in the Annexes A and C.
- Discussions with implementing partners revealed that more linkages and collaborations among different Sectoral partners would help more coverage and quality of the interventions– for example, a common partner coordination meeting and strategic workshops are suggested which would include all sectoral partners from SRHR programme, GBV programme, and A&Y partners. This would make UNFPA programme more effective and all other sectorial partners would be encouraged to make their interventions more gender and adolescent responsive. UNFPA has increasingly engaged with other actors, including development partners, to leverage their comparative advantages for better results for people.
-While it is difficult to generalize the nature of response to humanitarian crisis in CXB and other districts, UNFPA support to establishing referral pathways has been a positive effort. The support of the MoH is crucial in this and there is more room for improving the connectedness making the transition from humanitarian to development setting smooth and sustainable. Capacity building of service providers which would aid connectedness is limited to what is in the CP9 work plan. Strengthening communities on preparedness and resilience has not been part of the CP.

Partnerships, Coordination (plus coverage, coherence, connectedness) in Humanitarian Settings:

Given the limited funds and human resources UNFPA has for Humanitarian work, the coverage and coordination work accomplished are commendable. In terms of coverage, this has been discussed under effectiveness of the four outcome areas (SRHR, A&Y, GE and PD). The performance data in the Annex D also provide the data on coverage. In terms of connectedness, UNFPA strengthens the capacity of service providers through the development programme (SRHR, A&Y, GE and P&D) and IPs. However, capacity development of affected communities, CSOs and IPs has more room for improvement. Government structure (service coverage and facilities) are a limitation for improving the connectedness. In the case of CXB, it is a unique situation where moving from humanitarian to development stage is beyond UNFPA capacity and responsibility.
PD provides necessary data to take stock on coverage and data connects all the key agencies for evidence based planning and resource allocation. A cross-sectional study Rohingya need assessment survey completed and results disseminated to determine the health needs, identification of some accurate estimates and demographic profiling of Rohingya population living in Bangladesh. The study findings shared with UNFPA staff and other UN Agencies in Cox's Bazar, the report is being used as an essential element in programme planning for Rohingya people in Cox's Bazar.

Partnering with national actors to respond to humanitarian needs strengthen national leadership and ownership**.** UNFPA as the lead agency of GBVSS in humanitarian response to Rohingya influx has played a key role in responding to the crisis with its expertise on GBV and SRHR. But given the fact that other UN Agencies like UNWomen have overlapping agendas two TORs demarcating the areas of interests or roles as well as work out areas of cooperation have been identified. Image building by optimal usage of media projecting GBV issues has been a concern.

Both demarcations of areas of concern as well as overlapping interests with other UN Agencies was expressed as an area of concern by stakeholders at various levels. UNFPA being lead agency globally and nationally on GBV and lead player in SRHR issues had to face both the positive and negative effects of its agenda in collaboration with other partners especially UN agencies. Positively UNFPA demonstrated its technical proficiency in GBV through abiding by International principles and guidelines such as IASC. UN Agencies like UNWomen focused more on women's empowerment issues and hence had a broader agenda to fulfill like skills development for women and girls. Thus in the minds of government stakeholders especially, there was confusion. One top level government official remarked, *"UNWomen had a late entry into the camps, but was doing good work."* The same government official also admitted, *"GBV and SRHR, fundamental to UNFPA are very core issues both nationally as well as in the humanitarian sector. They also have a long standing existence in the area equal to UNHCR and WFP and yet their profile is not equal to theirs."* The strength of UNFP was thus perceived more from its sustained activities at the operational level.

Review of information related to use of media under the Knowledge Management and Communication Section in Q2 2019 report, it indicates media reports in SRHR and PD matters.[58] UNFPA sub office and country office felt that visibility of UNFPA on GBViE as well as the mainstreaming of GBV issues should be geared up. Furthermore, UN Women is in the process of supporting MoFA as lead ministry along with 12 other Ministries with a National Action Plan on Women, Peace and Security (based on UNSCR 1325).[59] As lead agency of GBV, UNFPA has a crucial role to play in engaging with this process. Given that UNFPA has the mandate, there is more room for expansion to work on preparedness planning, M&E in emergencies and coordination. More could be achieved with the engagement of UNFPA P&D unit staff and M&E staff and allocated funds for data needs at different stages of the humanitarian crises. While PD unit is engaged in the preparedness (mapping, data) it could be given a more visible and active role in the emergencies. Detailed data on coverage is included in the Annex C.
Facilitating factors: UNFPA mandate in humanitarian setting; GBV principles follow clear cut international guidelines in UNFPA programmes; long standing record of working in both development and humanitarian sectors; SRHR programme offers good service to this population; PD input in terms of data; and UNFPA coordinating role. **Constraining Factors:** Lack of media reports on GBV work; insufficient coordination between sectors in terms of Gender component; Overburdened staff; less visibility on the ground, compared to other UN Agencies such as UNHCR, IOM and WFP.

[58] Q2, 2019 monitoring report
[59] Gender evaluator was lead consultant in this process.

Chapter 5: Conclusions

(Note that CP9 had only two and half years of programme implementation (2017-2019 June) when this CPE was undertaken)

1. Aligned with national interests and policies, UNFPA strategic plans, mode of operation, and ICPD POA, CP9 stayed relevant to the country priorities, UNFPA mandate, and the needs of the beneficiaries in both development and humanitarian settings. UNDAF does include UNFPA mandated areas and continues to contribute to GOB priorities. Capitalizing on long term partnerships, UNFPA operates well with the government and non-government implementing partners as well as civil societies and academic institutions to achieve CP outcomes. Strategically, UNFPA CO is in a privileged position, closely operating with the parliamentarians on population issues, and has achieved remarkable results as evident by evaluation findings and performance data. Gradually, CP9 shifted its focus from direct service delivery to strengthen capacities of individuals, institutions and systems while establishing and expanding strategic partnerships to leverage resources. Increased emphasis on high-level policy advocacy and catalytic work, and establishing strategic partnerships have provided effective and replicable programme models as evident from the evaluation findings (Ref: SRH, AY, GEWE, PD effectiveness sections). While there is still room for UNFPA to advocate for some IPs to be operating under appropriate ministries to enhance functionality, requirements of the new programme (CP10) may need to explore multi-stakeholder partnership opportunities to produce more effective and sustainable outcomes. (Origin: EQ 1, EQ 2, EQ 7)

2) Strategically, UNFPA has maintained its strong presence in all policy and key decision functions related to UNFPA's mandate. **UNFPA's corporate strengths are well recognized and acknowledged by other UN members for the contribution in improving the UN Country Team (UNCT) coordination mechanism.** UNFPA has been a knowledge broker and partner in successfully bridging and facilitating various players engaged in the development field. While UNFPA has used its comparative advantage, taking the lead in advocating sensitive issues on human rights, ASRH, GBV, FP and HIV, there is more room for improvement in this area of advocacy. Moving into the role of technical support and advocacy, the need for increased technical capacity within UNFPA is critical to stay competitive in the UNFPA mandated specialties as the government expectation from UNFPA is more for technical assistance rather than financial support. *On the Operations and Management front, HR alignment is almost completed but some crucial and strategic positions are yet to be filled.* CO has established an effective M&E framework and a well-functioning M&E system. While CO has costed different modes of operation (capacity building, advocacy, KM etc.), an inclusion of costing of "soft activities" or staff time on advocacy, technical input and coordination would allow further analyses of efficiency and effectiveness of UNFPA input in upstream advocacy and catalytic work. UNFPA human and technical resources are of critical importance to advance in-country programmatic and advocacy agenda and remain relevant to cover the emerging national development priorities. Due to the growing demand for advocacy and partnerships, technical support and coordination for ambitious 2030 Agenda, joint UN work in light of the UN Reforms, and finding sustainable solutions for upscale programming, UNFPA should focus on its comparative advantage and maintain or scale up the presence in the country, both in the development as well as humanitarian contexts. (Origin E1, EQ3, EQ 4, EQ 6, EQ 7)

3. ***Advocating for SRHR, ASRH, and GEWE, providing quality data for evidence based planning and policy making, and providing access to information and knowledge as a human right, CP9 implementation has employed gender-accommodating and human rights-based approach to achieving the results.*** UNFPA has promoted creativity and innovation specifically embarking on non-traditional areas such as midwifery, prevention of harmful practices for young females, and in sexual and reproductive health areas and GBV case management in development settings. There is room to

lobby stronger on rights issues and male engagement in SRHR and GBV where the government agencies are weak in promoting interventions, formulating policies and/or implementing current policies. As a development partner, UNFPA is valued for the technical assistance it provides the country. UNFPA CO has established sustainable and strategic partnerships, especially in the PD area, enabling a healthy environment (at a higher level) to lobby for areas such as stop child marriage, GBV and SRHR that are culturally sensitive, deep-rooted and difficult to change. Origin EQ1, EQ3, EQ5, EQ 7

4. *The programme has made a deliberate effort to include vulnerable and marginalized groups, addressing the Agenda 2030 principle of 'leaving no one behind', including a focus on ethnic groups, tea garden workers, brothel based sex workers and fistula patients etc.* However, *UNFPA focus on the marginalized groups could be more targeted*: Given the use of data and criteria employed in the selection of CP9 proramme areas, including disaster prone areas, it is evident that UNFPA made a deliberate attempt to include marginalized and disadvantaged groups in the design and programme implementation. However, at a more strategic level, data gaps remain that call for strengthening government capacity to generate evidence base data to inform inequalities. Unless the inequalities are correctly identified the interventions can be less effective and efficient. Addressing "Leaving no one behind" will be more successful if these data gaps are filled. Furthermore, work at the sub-national level and inclusion of districts with marginalized groups within the nineteen focus districts of CP9 is based on a number of social development criteria relevant to the UNFPA programme, resulting in the selection of districts in five divisions of the country. The combination of generic criteria on the one hand and selection of most vulnerable groups on the other, is as such understandable and useful, though it has implications for how the lessons learned and evidence produced from the various programme sites can be used to inform the future programme. (Origin: EQ1, EQ2, EQ 3, EQ4, EQ8)

5) V*arious components of CP9 appears unevenly spread over the 19 focus districts. For the programme to increase its success in each of its components it will need to enhance the scale that issues are dealt with. This goes for each of the three components of the SRHR outcome area as well as for parts of these.* Partly this relates to differences in funding for components of the SRHR programme. However, this means in practice that the various parts of the SRHR programme cannot always be integrated in all districts. This also goes for the integration of SRHR with other outcome areas of the programme, which can only be realized in part of the 19 districts. Connections between early marriage and fistula for example, would have been useful in the haor areas in the northeast of Bangladesh, if there would have been adolescent and youth programming in districts concerned, to have more impact with comprehensive programing approach. There is a need for a clear approach on government take-up of programmatic approaches and learnings in additional areas beyond the 19 UNFPA priority districts, expanding the reach of SRH services to an increased number of women and girls. This will require identification from the start those parts of the programme that will be used in a piloting approach and those parts concerning direct support to service delivery. At the same time, there is a need to identify areas where UNFPA would gradually be phasing out. This will enable UNFPA to increasingly engage in new programmatic areas, like urban programming. (Origin: EQ1, EQ3, EQ5)

6. The programme has usefully combined a focus at the national level emphasizing on policies, strategies and plans, with support at the sub-national level, in order to support implementation at the district, upazila and facility level. This goes in particular for the MNH component of the programme which focused on the development of midwifery as a profession in order to enhance access to SRH services across the country and in particular for people in remote and underserved areas and for members of vulnerable and marginalized groups. The systemic approach that has been applied to midwifery faculty has the ability to provide sustainable results, assuming that GOB will remain

committed to the approach and continues to include newly graduated batches of registered midwives into the health human resource system. (Origin EQ1, EQ3, EQ4, EQ5)

7. Given that **urban health** is a new area for the country office, there is a need to engage additional government agencies in charge of urban health, CO programme staff across all outcome areas and cooperation across UN partners, composition of which will need to be based on the specifics of the programmatic engagement. In the development of urban programming there will be an important role for the PD outcome area of the programme, in order to provide the required analysis, on processes of urbanization and migration and other relevant topics, aimed at the development of an evidence-based approach to the development of programme interventions. (EQ7)

8. Adolescent &Youth programme was successful in its cross-cutting function contributing to SRHR and GE outcomes. **Building on** ***lessons learnt from CP8, A&Y programme focus was realigned to encompass adolescents in CP9*****.** ***UNFPA is supporting the development of policies related to adolescents' sexual and reproductive health in Bangladesh using Human Rights lens.*** A&Y interventions have been effective in disseminating SRHR and GBV information and enhancing awareness, and promoting adolescent friendly services at health service points. A&Y interventions are *on track that aim for reduction in GBV, child marriage, unwanted pregnancies, unsafe abortions, maternal mortality and the spread of HIV and other STIs*. UNFPA's contribution to facilitate adolescent friendly health services and their work on the development of policy documents, protocols and standards of delivering SRHR/ASRH services in the country is commendable. The programme was successful in drawing government attention to identify adolescents and youth as a special group that are vulnerable to risks such as gender based violence, early marriage, teen pregnancies and risky behavior due to the lack of knowledge and information on sexual and reproductive health. The technical capacity of MoWCA, the nodal Ministry with the mandate for the development of women and girls, has HR capacity which compromises the quality delivery of interventions. Implementation of existing progressive laws and policies continues to be a challenge, mostly due to inefficiencies arising from a large, complex government machinery, weak systems and lack of capacity. MoWCA would benefit from input on adolescent responsive programming and SRHR training to help strengthening the ministry's capacity**.** (Origin EQ1, EQ3, EQ4)

9. ***UNFPA contributed to the development of a functional integrated information system for the formulation, monitoring and evaluation of national and sectoral policies Indicators***. Working closely with the parliamentarians is a special niche that UNFPA CO developed and has set the stage for enhancing the achievement of "three zeros." However, the data inconsistency at national level has been an issue faced by planners and researchers. Different sources of data for the same indicator have been a challenge for decision makers. UNFPA has prepared a proposal on Survey data harmonization, but it has not being followed up. There is a need to streamline the national data, for example data on ending child marriage (ECM) which is one of the result indicators and currently reported data in MICS and DHS are inconsistent and different ministries use different sources. (Origin EQ3, EQ4, EQ6)

10. ***A substantial effort has been made in the gathering of monitoring data at sub-national level by field officers, which data have been used to inform programme management and reporting. Results of analysis can, moreover, be used for advocacy towards GOB and other stakeholders***.

The investment made in monitoring of results in the SRHR component of the programme has additional potential as these data can be further analyzed to support the evidence-based approach of the programme and inform the development of the new programme cycle. Such analysis needs to be underpinned by a clear methodological basis, which could include for example enabling comparison of

the results of similar SRHR programming in different contexts as well as different aspects of SRHR programming in similar contexts. The use of analysis can be enhanced in the quarterly reports of several of the IPs, to move beyond reporting on activities to include a focus on output level changes and how these were realized, highlighting facilitating as well as constraining factors. The findings of such analysis could in turn inform the IPs as well as programme management staff to enhance results.(Origin EQ3, EQ4)

11. ***UNFPA is in a unique position being a global leader in several fields such as population data, sexual and reproductive health and rights, GBV, and more recently/ in the Humanitarian response and crisis preparedness.*** **The relatively lesser importance given to PD within the overall CP may weaken the central glue that P&D unit provides UNFPA in its policy advocacy role.** Population dynamics should become a central key variable when designing and planning the development programme in CP (given prominence as a macro-level variable in development,) which also helps support UNFPA interventions in SRHR, GRWE and AY. While maintaining the technical contribution, resource mobilization will also need to become a key part of the UNFPA CO agenda in CP10. (Origin EQ 3, EQ 4, EQ7)

12. ***Synergies across outcome areas as well as output groups: Weak synergies between output groups were observed within CO.*** The organizational structure itself may have contributed to this silo approach. Program staff responsible for a particular output (even within the same Outcome areas) paid less emphasis to information sharing and internal communication between thematic areas. However, there are cross-cutting areas such as gender and youth, working with SRH teams and PD working with other outcome teams providing data input. There is more room for enhancing synergies across the outcome areas. (Origin EQ3, EQ4, EQ6)

13. Similar pattern was observed in the humanitarian setting in CXB, where Implementing Partners (IPs) exposure to limited opportunities to share their suggestions and views on project implementation directly with UNFPA programme teams. IPs wish to be exposed to all other interventions, not only in their field, that UNFPA support. Currently, such opportunity to learn from each other and strengthen the IP programme outcomes is limited. According to the IPs (in CXB), only time they got that common exposure to learn what other IPs contribute to UNFPA planned outcomes was when the Evaluation Team had a meeting with all IPs supported by UNFPA in CXB.(Origin EQ5, EQ6, EQ 8)

14. ***UNFPA has been effective in responding to humanitarian needs and is a leading advocate for women in emergencies***. UNFPA has effectively translated its emergency response from general preparedness in emergencies e.g. through rolling out Minimum Standard of GBViE, a comprehensive strategy with gender-based violence as a frontline focus e.g. through streamlining case referral and management systems among relevant stakeholders. UNFPA has contributed invaluably in bridging the humanitarian-development divide. While there is still work to do on this especially in the Rohingya influx situation in Cox's Bazaar, strengthening of existing institutions of host communities that can bolster humanitarian interventions in the camps is a strategy that is being encouraged at the national level as well.. Keeping in line with both its global mandate as well as national priorities, the UNFPA could translate this into a strategy when developing CP10. However, in the Humanitarian sector, UNFPA has received relatively less attention than it deserves. Referring to visibility, UNFPA has the potential to address the image issue by establishing links and developing synergies between different components like P&D, Gender, A&Y and SRHR, not only in the development sector but in humanitarian sector as well. The gender mainstreaming can be strengthened. (Origin EQ7, EQ 8)

Chapter 6: Recommendations

The following recommendations are based on the evaluation findings and conclusions discussed above and feedback received from key stakeholders. From a long list of recommendations, only 10 recommendations are prioritized: five strategic and five programmatic ones. These are within the responsibility of UNFPA CO, with support from the government, other development partners, APRO and HQ. UNFPA support is mainly in terms of technical assistance, advocacy and capacity building. Implementation of the recommendations may require joint effort of relevant stakeholders, including UN agencies and CSOs. Time period is for CP10 and some design and HR related recommendations may have to be implemented during CP9 (2020) in preparation for CP10. The evaluation team does not have information on resource allocation for the action plans.

6.1 Strategic Level Recommendations

Recommendation 1 (Linked to Conclusions 1,2,11,12) Priority Level: High **Continue to strengthen the strategic partnerships with key government and non-government agencies. Given the mode of engagement and programming needs, UNFPA should maintain its leadership in assisting the government with strategy and policy development, advocacy role and technical assistance where necessary. Increased technical capacity within UNFPA is critical to stay competitive in the UNFPA mandate specialties.**
Responsibility: UNFPA CO
Action Plan - Continue to work with parliamentarians to lobby for sensitive issues (related to rights issues) within UNFPA mandate that will contribute to long-term results (beyond this CP cycle) which encompass all UNFPA programmatic areas and multiple implementing and development partners. - Population dynamics is crosscutting and has significant potential benefit to the country programme if UNFPA could lobby for PD to be more central to development management and planning. -Establish a clear and stronger advocacy strategy to fully utilize the generated population data for policy making and planning by high level decision makers at all levels. -Support with capacity building to integrating demographic data and projections into development planning. Continue with innovative interventions such as capacity building on NTA (currently stopped due to lack of funds) -P&D unit/UNFPA has the potential to greatly impact policy making and planning and to play a leading and a central integrating role in (the rest of CP9 as well) CP10. Seek to build a higher profile for the unit within the Country Office. To enhance full and effective implementation of the policies, UNFPA to lobby and advocate for functionality of relevant departments and agencies (e.g. NSO, NPC etc.). -maintain a highly qualified staff to cater to advocacy agenda and to remain relevant to emerging needs of the national development priorities.
Recommendation 2 (Linked to Conclusions: 4,8,9) Priority level: High **Continue to advocate for harmonization all demographic surveys in the country and for the full implementation of Statistical Act 2013.**
Responsibility: UNFPA CO (with other UN agencies and relevant government authorities)

Action Plan
-Assess the current status **-**Lobby (for the implementation of Statistical Act 2013) together with other relevant and appropriate UN agencies
-Streamline the National Data on Ending Child Marriage (ECM) which is one of the result indicators. The national data on child marriage as reported in MICS and DHS are inconsistent.
-Facilitate coordination of ECM data to streamline the with BBS and Directorate General of Health Services (DGHS), the Ministry of Health and Family Welfare, and MoWCA to explore strategies to collaborate to overcome the data inconsistency (Currently, the Ministry of Women and Children Affairs are following the data provided by the Multi-Indicator Cluster Survey (MICS) conducted by BBS which collects data at the district level, on the contrary the Demographic Health Survey (DHS) facilitated by Directorate General of Health Services (DGHS) and supported by UNFPA which collects data from the divisional level have reported two different rates of Child Marriage data).

Recommendation: 3 (Linked to Conclusions: 1, 2,7,8,11,12,13) Priority level- High

CP10 to establish cross functional teams (in the country office) to avoid vertical project planning and management. Develop a Theory of Change for the entire country programme with a clear and shared understanding of how all parts of the programme fit together to provide a framework indicating linkages across parts of the country programme. This will be timely, given the UNSDCF preparation and to avoid any overlaps. Currently, each individual programme outcomes are explained by separate TOCs. Focus on planning that multidisciplinary teams are collectively accountable for final results.

Responsibility: UNFPA CO all staff (APRO may participate)

Action Plan -
-Organize a full day (or two) workshop with all programme managers and staff involved in CP10, facilitated by a moderator to discuss the root causes and the barriers that are being addressed by the Country Programme. Develop targets and indicators and risks and assumptions framework. (Assess how CP10 fits within UNSDCF)
-Develop a Theory of Change for the entire CP with a clear and shared understanding of how all parts of the programme fit together and develop linkages across parts of all outcome areas of the UNFPA programme.
- Expand the existing functional M&E system of CO to design and track how indicators can be put in place to measure the collective outputs (as indicated in the comprehensive TOC).
- The CO to allocate financial resources to build program staff capacity at CO in the required skill areas as determined by staff and the programme direction.
- M&E function should be well integrated in to each output team, working towards collective results in achieving the outcomes. Current M&E unit to be responsible for overall reporting and monitoring progress of indicators, working closely with UNSDCF and SDG monitoring.
-CO has a fully developed, well functional M&E system including up-to-date financial data, develop behavior change measurement tools to be included in the CO M&E system (linked to TOC)

Recommendation 4 (Linked to Conclusions: 1,2,3,8,13,14) Priority level- High

Keeping in line with international guiding principles, advocate for increasing the effectiveness of GBV related programs for greater impact on national agenda by increasing national image building activities and mainstreaming GBV concerns and issues among all key national level stakeholders and GBV related programs of UNFPA that are inclusive of both development and humanitarian sectors. Include stronger public health interventions and multi-sectoral interventions aiming to address Violence Against Women (VAW).

Responsibility: UNFPA Country Office (Gender Team in CO and CXB Sub-Office)

Action Plan

-Coverage of capacity-building programmes on GBV related issues could be extended to all relevant stakeholders to include legal professionals and administrative personnel in Government

-Refreshers courses may be held on GBV issues more frequently for participants where there are frequent postings such as the police and other administrative personnel.

-Provide inputs to other sectors like P&D, A&Y and SRHR to strengthen gender mainstreaming with UNFPA; Innovative joint programs could be launched where intersectionality between GBV, SRHR and A&Y issues converge.

-Necessary advocacy with the national government to be taken up on a priority basis.

-GBViE should receive frontline attention but at the same time synergies between the development and the humanitarian sectors must be explored to set an exemplar of how to transcend the humanitarian-development divide

-Youth as well as male participation (as beneficiaries as well as possible volunteers) to be enhanced to increase effectiveness of these efforts. These approaches should be thoroughly evaluated to use as information basis for scale-up and replication.

-Media reports and engagement on GBV related activities should be stepped up and promoted

-Identify the role of men and boys in interventions on GBV and violence against women and assess vulnerabilities of men and boys and their needs in relation to GBV.

-Build capacity of men and boys to engage as change agents to promote GE

Recommendation: 5 (Linked to Conclusions: 1,2,4,8, 13,14) Priority level - Medium

Continue work on bridging the humanitarian-development divide. Include interventions in support of strengthening the capacity of local service providers and national actors to identify and deal with risks, vulnerabilities and their underlying causes.

Responsibility: UNFPA CO and CXB sub-office (with RCO and APRO)

Acton Plan

-Links and synergies between development and humanitarian divide to be explored and established; a study maybe launched to this effect.

-Policy and strategic coordination between development and humanitarian sectors to take place. This may entail review of financial allocation and office structures.

-Allocation of resources for capacity building. Design resource mobilization plan specifically for improving resilience

-Specific to CXB, strengthen existing institutions of host communities that can bolster humanitarian interventions in the camps. Allocate resources for the host communities for development interventions in the UNFPA outcome areas.

-Invest in conflict sensitivity programmes as the tension between the Rohinya and host communities may rise up in the future.

-Use the established networks and cluster system to encourage a multi-sectoral, multi-partner participation, including the participation of the people affected (or at risk) to understand the multiple causes of vulnerability and fragility for sustainable resilience building.

-Improve the availability of gender-sensitive and disaggregated data to inform programme responses

-Capacity building of local service providers (connectedness)

-Increase the focus on AY programming including resource mobilization and capacity development of local service providers to deliver effective programmes.

6.2 Programmatic Recommendations

Recommendation: 6 (SRHR) (Linked to Conclusions: 6,10,12) Priority level- High **Address the constraints that remain in the implementation of the MNH component of the programme in order to enhance results and ensure their longer term sustainability.**
Responsibility: UNFPA CO (together with government and other implementing partners of the programme)
Action Plan -further strengthen the quality of midwifery education in particular faculty development and its mentorship components, -ensure that newly graduated and placed midwives receive close mentoring and supervision during a one year period -expand the coverage of 24/7 EmONC services and their accessibility so that all women in critical need can get lifesaving care; (services do not seem to be provided in practice based on reporting) -advocate for addressing the rise of non-medically indicated C-sections, resulting in enhanced morbidity and mortality for women; -enhance and expand community related component beyond the use of social media, in particular to reach women and girls in rural areas -Enhancing demand will need to keep pace with the increased supply of SRH services. -address the significant burden on RH morbidities in particular through convening partners around the effort to eliminate cervical cancer and obstetric fistula.
Recommendation 7: (Linked to Conclusions:2,4,5,10,12,14) Priority level- High **(SRHR and A&Y)** **Support the access of adolescents and youth to realize their SRH rights and have access to quality SRH services, tailored to their specific needs**
Responsibility: UNFPA CO (in cooperation with government and other partners)
Action Plan -To review the approach to adolescents and youth access to SRHR through a A/Y corner and identify under which conditions such an approach is successful and where it has not worked to enhance adolescents and youth' access to SRHR. (SSC experience exchange on these) -To establish linkages between the SRHR and A/Y component in those districts where both components are implemented and ensure the inclusion of both programme components in areas with high rates of child marriage and obstetric fistula - To pay attention to adolescents and youth when developing the urban programme, ensuring that their rights and needs are sufficiently incorporated into programmatic design and implementation. -To ensure disaggregation of SRHR monitoring data by age group and sex disaggregated where relevant and to analyze the data for adolescents and youth, in particular for young adolescents, in order to inform results-based management of the programme component. - Develop a methodology for the analysis of the vast amount of monitoring data gathered in the SRHR outcome area, aimed to provide a basis to the development of evidence on what works and what does not in focus districts in the SRHR programme, in order to inform the next programme cycle.
Recommendation 8: (PD) (Linked to Conclusions: 4, 9, 11) Priority level: High **Support government capacity to generate (disaggregated) data to close data gaps that limit addressing inequalities. The focus on the marginalized groups to be more targeted.**
Responsibility: UNFPA CO

Action Plan Support closing the gaps in data by strengthening government capacity to generate evidence base data to inform inequalities.
- Identify the marginalized and vulnerable populations by geographic areas. Produce disaggregated data for targeted planning (to address disparities and inequalities).
-Support for appropriate analyses to design and implement effective development strategies and monitor programme performance and impact.
-Support generation of data during different stages (specifically relief and recovery) of the crisis in humanitarian setting to identify the needs of the people, as needs change.

Recommendation 9: (SRHR) (Linked to Conclusions: 2, 7,10,11,12) Priority level - Medium

Prepare for programming in urban areas, including slums in Dhaka as well as a limited number of other divisions, with inputs from across the UNFPA outcome areas.

Responsibility: UNFPA CO (other relevant agencies)

Action Plan
-Conduct this in cooperation with other UN agencies and informed by the urban programming of other development partners.
-Link programme development with the PD part of the programme, ensuring the availability of the required relevant population data to inform urban programming, including analysis of urbanization trends and other relevant topics
-In addition to a focus on slums in Dhaka, it will be useful for UNFPA to explore the opportunities for urban work in selected other divisions, including partnering opportunities.

Recommendation 10: (A&Y) (Linked to Conclusions: 4,8) Priority level - Medium

For CP10, more resources need to be allocated to integrate out of school children under Life Skills Education Programme since they are unable to access academy based curriculum. Integrating out of school children under LSE programme is difficult since they are already engaged in the informal labour force. However considering their large number and vulnerability, UNFPA to consider LSE programme to be integrated/blended with skill training programmes in partnership with relevant partners (WB, ILO, UCEP, etc.).

Responsibility: UNFPA CO (with GoB, concerned UN agencies, Donors, NGOs & CSOs)

Action Plan:
- Assessment of the volume of out of school children who cannot access academy based curriculum
- Assess resource allocation plan within UNFPA and advocate for resources needed for the out of school adolescents and youth to address their SRHR needs.
- To initiate online SRHR literacy programs - online contents for social media platforms (Facebook, YouTube) and interactive contents catered for youth and adolescent based on their interests that can help trigger behavioral change in young people.
- To impart SRHR literacy program with skills development training institutes under various vocational trades.
- design appropriate interventions to reach out of school adolescents through UNFPA programming efforts in case there are lack of support from GoB/ relevant stakeholder.
-- Organise a few rounds of discussions with collaboration partners (Donors, UN, NGOs and GoB) to explore strategies to integrate out of school children under LSE programme
- Explore potential partners to integrate LSE with existing/new skills training programme to enhance ASHR knowledge among out of school girls and boys
- Explore funding opportunities/ ensure allocation of fund for LSE programme blended in skills-training programme