FINAL REPORT

EVALUATION OF
THE 7TH COUNTRY PROGRAMME

UNFPA BANGLADESH

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This evaluation has been commissioned by UNFPA Bangladesh. The views and opinions are those of the consultants and do not necessarily reflect the views and opinions of the Government of Bangladesh or of UNFPA.
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The zila, upazila and union managers/officials, directors and staff received us with openness, time and commitment to both, to progressing in reproductive health, family planning and the gender agenda and to the contribution the evaluation hopes to make to this process. We want to convey our appreciation for their commitment and their investment in the process. The ET would like to express its gratitude to the officials and individuals of the Ministry of Health and Family Welfare, the Ministry of Women and Children Affairs in Dhaka, the representatives of the Economic Relations Division, the Parliamentary Secretariat, Planning Commission, Department of Population Sciences of Dhaka University, Bangladesh Bureau of Statistics, the Ministry of Education, Ministry of Finance, Ministry of Home Affairs, Ministry of Local Government, Rural Development and Cooperatives, Ministry of Religious Affairs and Islamic Foundation and Imam Training Academy, the Ministry of Youth and Sports, the Tea Garden, the Bangladesh Garment Manufacturers’ and Exporters’ Association and to the UNFPA staff, who provided insight and background information.

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PICTURE 1: OUR THANKS

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### LIST OF ABBREVIATIONS, ACRONYMS AND GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Ante - Natal Care</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<td>AWP</td>
<td>Annual Work Plan</td>
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<tr>
<td>BBS</td>
<td>Bangladesh Bureau of Statistics</td>
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<td>BCC</td>
<td>Behavioural Change and Communication</td>
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<td>BGMEA</td>
<td>Bangladesh Garment Manufacturers' and Exporters' Association</td>
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<tr>
<td>CCA</td>
<td>(UN) Common Country Assessment</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CEDAW</td>
<td>Convention on Elimination of All Forms of Discrimination Against Women</td>
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<td>CSBA</td>
<td>Community Skilled Birth Attendants</td>
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<tr>
<td>CO</td>
<td>Country Office</td>
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<tr>
<td>CP</td>
<td>Country Programme</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CRHCC</td>
<td>Comprehensive Reproductive Health Care Centre</td>
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<td>CSO</td>
<td>Civil Society Organisations</td>
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<td>Dex</td>
<td>Direct Execution</td>
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<tr>
<td>DFID</td>
<td>United Kingdom Department for International Development</td>
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<tr>
<td>DGFP</td>
<td>Directorate General Family Planning</td>
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<tr>
<td>DGHIS</td>
<td>Directorate General Health Services</td>
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<tr>
<td>DIO</td>
<td>District Information Office</td>
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<tr>
<td>DPS</td>
<td>Department of Population Sciences</td>
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<td>DWA</td>
<td>Department of Women Affairs</td>
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<tr>
<td>EoC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>ERD</td>
<td>Economic Relations Division</td>
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<tr>
<td>EoC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GAD</td>
<td>Gender And Development</td>
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<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GoB</td>
<td>Government of Bangladesh</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HNPSP</td>
<td>Health, Nutrition and Population Sector Programme</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEM</td>
<td>Information, Education and Motivation</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IP</td>
<td>Implementing Partner</td>
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<td>Ki</td>
<td>Key Informants</td>
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<td>LCG</td>
<td>Local Consultative Group</td>
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<td>MCWC</td>
<td>Mother and Child Welfare Centre</td>
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<td>MDG(s)</td>
<td>Millennium Development Goal(s)</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MoHA</td>
<td>Ministry of Home Affairs</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MoI</td>
<td>Ministry of Information</td>
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<tr>
<td>MoLE</td>
<td>Ministry of Labour Employment</td>
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<tr>
<td>MoLGRD</td>
<td>Ministry of Local Government, Rural Development and Cooperatives</td>
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<tr>
<td>MoRA</td>
<td>Ministry of Religious Affairs</td>
</tr>
<tr>
<td>MoWCA</td>
<td>Ministry of Women and Children Affairs</td>
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<td>MoYS</td>
<td>Ministry of Youth and Sports</td>
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<tr>
<td>MTR</td>
<td>Mid-Term Review</td>
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<td>MYFF</td>
<td>Multi-Year Funding Framework</td>
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<tr>
<td>NAP</td>
<td>National Action Plan for Advancement of Women</td>
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<tr>
<td>Nex</td>
<td>National Execution</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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</table>
Community Participation and Consultation is the process of sharing information, seeking inputs from community about the project, seeking community-wide inputs, and integrating those in the project design as well as in planning mitigation measures.

Gender refers to the social differences between males and females that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures. “Gender” determines the roles, responsibilities, opportunities, privileges, expectations, and limitations for males and for females in any culture (IACS, 2005).

Gender Based Violence (GBV) is violence that occurs as a cause and consequence of gender inequity. It includes a range of violent acts rooted in gender inequities in various cultures and societies across the globe. Gender Based Violence is for the large majority perceived as violence against females committed by males, within the context of women and girls subordinate status in society, and serving to retain this unequal balance (Human Rights Watch, 1996). GBV includes, but is not limited to domestic violence including Intimate Partner Violence (IPV), Sexual Violence (SV), Violence against Women (VAW), human trafficking and traditional harmful practices. Gender-based violence affects all genders.

Growth Rate is the average annual percent change in the population, resulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving a country. The rate may be positive or negative. The growth rate is a factor in determining how great a burden would be imposed on a country by the changing needs of its people for infrastructure (e.g. schools, hospitals, housing, roads), resources (e.g. food, water, electricity), and jobs. Rapid population growth can be seen as threatening by neighbouring countries.

Survivor or Victim of GBV is a term used to describe a person who has experienced gender-based violence (and survived). Legal and medical personnel often use the term “victim” to describe a survivor of GBV.

Union: The lowest level of local government constituted under the local government ordinance

Upazila: Sub-district

Zila: District
EXECUTIVE SUMMARY

According to the UNFPA Evaluation policy, an end of programme evaluation is mandatory and should be carried out in the penultimate year of the country programme. The 7th Country Programme (CP) of UNFPA in Bangladesh (2006 - 2010) was extended by one – year cost extension. The evaluation was carried from 4th December 2010 to the 6th January 2011 and had the general objective to assess the achievement of the programme at the end of the programme cycle and contribute to the formulation of the 8th CP. Therefore the evaluation was requested to conduct a strategic, not an operational review.

The 7th CP is built on the experiences of earlier CPs and reflects the International Conference on Population and Development (ICPD) agenda, the Beijing Plan of Action, the priorities of the UN Common Country Assessment/United Nations Development Assistance Framework, the UNFPA Multi-Year Funding Framework (MYFF) (2004-2007) and UNFPA’s strategic plan (2008-2011). The CP has also taken into account the Millennium Development Goals and Poverty Reduction Strategy Paper targets. The programme intended to emphasise capacity development, service delivery, with particular focus on the poor and vulnerable populations, and gender equality and the empowerment of women, with special emphasis on gender-based violence (GBV). This programme also supports the Health, Nutrition and Population Sector Programme through the support of the health SWAp pool with a small proportion of funds. The CP was designed to be nationally executed with the Government of Bangladesh (GoB), in close partnership with other UN agencies, NGOs and the private sector. The results and

### Table 1: UNFPA 7th CP Components

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Reproductive Health</th>
<th>Gender</th>
<th>Population &amp; Development</th>
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<tbody>
<tr>
<td>Outcome 1:</td>
<td>Population and reproductive health strategies (the PRSP, MDG report, the SWAp and the population policy) are effectively translated into programmes, especially for the poor and vulnerable.</td>
<td>Women and girls are supported and empowered to make decisions about their reproductive health and rights.</td>
<td>A policy environment that promotes reproductive health and rights is created.</td>
</tr>
<tr>
<td>Outcome 2:</td>
<td>Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS.</td>
<td>7 M US$ (7 M regular, 8 M other resources)</td>
<td>4.45 M US$ (4.45 M regular, 0.5 other resources)</td>
</tr>
</tbody>
</table>

The interventions in the zilas were supposed to be coordinated through two UNFPA sub-offices. Sixteen implementing partners (IPs) from twelve ministries, one NGO and an autonomous body (Bangladesh Garments Manufacturers and Exporters association – BGMEA), are carrying out the activities. The Economic Relations Division (ERD) of the Ministry of Finance (MoF) has been the overall coordinating GoB agency for all UN agencies, including UNFPA.

Next to the CP, UNFPA Bangladesh engaged in high policy debates, facilitated by a contribution to the health SWAp pool, and in three joint programmes such as the Demand based RH commodity project (funded by the Canadian International Development Agency, recently concluded), Accelerating the reduction of maternal and neonatal mortality and morbidity (funded by the United Kingdom Department for International Development and European Union) and the UN-GoB Joint Programme on Violence Against Women in Bangladesh (MDG Spain fund). In each component several projects intended to contribute to the outcomes of the RRF. The report elaborates on the progress and constraints of these projects in view of a strategic (not operational) contribution to the 8th CP.

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**Final Report – February 2011**
In summary the following observations were made, while it shall be stated that the completion by UNFPA of a high workload, multiple tasks and activities are recognised and appreciated.
The RRF is inconsistent in its design and does not provide a strategic direction. Hereby it is also of limited use for an evaluation process. However, in summary it can be stated that UNFPA supported the project implementation of multiple governmental and non-governmental partners effectively as far as the projects were designed and planned. The evaluation received limited information to elaborate well on efficiency. Impact is cannot be assessed well due to the RRF. A strong weight on knowledge transfer in various ways in almost all projects is the main contribution which has a higher likelihood to be sustained, however faces limitation by factors beyond UNFPA’s influence such as high turnover of staff; weakness (though improving) in the health systems, whereby it is debatable to which extent UNFPA should or could have influenced incompletely designed interventions by partners.
In brief, it seems fair to say, that UNFPA have been engaged with its 7th CP in Bangladesh in a large variety programme-, policy-, strategic interventions which all, individually assessed, have to be considered useful and benefitting, while many lack coordination, completeness and/or quality. This should not be understood as questioning the relevance of the interventions, rather as pointing at the need for a common strategic direction, collaboration (within UNFPA) and an overstretched CO which requires investment in its capacity and strategy.

Having said so, as agreed during the inception of the evaluation, the aim of an CP evaluation exercise goes beyond a review of the performance of an agency and of individual projects, but to look at the entirety of the programme and identify those issues which can guide for the next CP.
The 7th CP confirms that a well thought through RRF is essential. The inconsistent RRF of the 7th CP had major consequences throughout the period. While on the one side the activities were carried out to a large degree as planned in the Annual Work Plans, the UNFPA office seems to have gotten overwhelmed in following up and implementing projects rather as stand-alone interventions and in absence of committed common programmatic strategies, the direction was unclear. This led also to a disconnection between project implementation and high level policy inputs. The Mid-Term Review (MTR) was carried out late in the CP cycle and, although the MTR pointed out the weaknesses, there were hardly options to act during the life time of the projects. Inevitably the RRF was of limited use for ongoing monitoring, equally for the final evaluation. Hence monitoring was not done systematically.
The unclear UNFPA strategy – and possibly an office which needed time to recognise the need to move beyond projects and deal systematically with policies might have been the cause that programmatic strategies were not or insufficiently developed. In turn UNFPA did participate in technical fora, but did not or was not perceived by some partners to assume the role of a lead agency in RH, fertility reduction and gender agenda. At the same time UNFPA increased its visibility in high levelled debates, coordination among UN-agencies and bilateral donors, and the Local Consultative Group debate through a proactive engagement. These debates were policy elaboration and advocacy and addressed the cooperation between donors and the Government of Bangladesh (GoB).

The UNFPA projects have gained some positive lessons, to mention a few of more: staff cadres/volunteers who are reaching personally households and individuals present good experiences in urban health for the identification of poor, ensuring services for poor and innovative systems; the cooperation in service provision between the profit making as well as non for profit private sectors and the public sector; the effect of training youth peers in and outside schools. These lessons could be captured and used for conceptualisation.
The UNFPA office was largely busy and fulfilled numerous tasks relevant for the RRF. The RRF and even more so the individual projects were designed rather based on historical background than on updated situation analyses and needs assessments. The interventions were/are rather “more of the same” than moving in a joint strategy. This is of course not to say that UNFPA would need to take all agendas on board, but UNFPA could make the linkages to respective offices and Ministries and assist them programmatical and technically in their own think tank and plans or act as mediator and guide them to respective agencies or technical assistance of other partners with the respective expertise (and possibly funds). Although all components are well aligned with country polices and priorities, the projects seem often reflect incomplete concepts and/or implementation. A few examples are listed:

- The gender component addresses mainly awareness creation of GBV, dowry and early marriage, which are surely priorities and present a useful starting point and work eventually towards equity. However major pillars in the gender agenda, as mainstreaming, empowerment, access of women to
work, services and resources, decision power sharing in household, social life, are not conceptually captured and indicating if and how the awareness creation is contributing. In providing care for victims/survivors of GBV shelter and food are offered, but psychosocial care, empowerment for income are included only in some cases, which in turn raises the question whether the victims are indeed assisted in getting out of those problems which brought them into the situation in the first place. Similarly, fistula patients get access to operations, which of course is essential for them. But, especially those women who get unsuccessfully operated, as well as their husbands, require psychosocial assistance to cope with their situation.

- Skilled Birth Attendant (SBA) training and awareness creation was and is surely essential. However these alone cannot reach the level of attended deliveries as stated in the related outcome. An essential additional element would be “gender”, not “women” empowerment (e.g. decision making power to access services, rights for their own (reproductive) health) which is required to meet RH needs.

Without a comprehensive situation analyses on gender, and its relation to RH, plans might stay overly optimistic and not reaching its envisioned outcome. The population and development component should also support MoWCA how to incorporate population and gender issues into the development of the sector and systems. This “gender mainstreaming”, even though expressed in descriptive phrasing, was aimed at through separate projects, which were not really designed to be enabled to build the capacity in the relevant line Ministry in assuming its mandate and responsibility. Eventually gender mainstreaming was not streamlined and addressed by neither component.

- While the programme documents state poor and vulnerable groups as target groups with special importance, the conceptual framework remained incomplete since poverty profiling was not adequately addressed through the current CP.

- If trainings, orientations and alike remain as one – off actions, or research and studies not leading to programmatic or policy decisions, than their added value is questionable and the funds are likely not be well spent (“value for money”).

If a geographic focus is chosen, then an area specific analysis of the situation at present, its specific constraining factors, problems and gaps as well as openings, opportunities and facilitating could/should be the basis for planning to indeed make use of the approach and address the specific characteristics of the zila. Similar counts for target specific needs and approaches: RH promotion did not yet address pockets, especially the youth, poor, teenage couples, difficult to reach areas, social pockets like minority groups, host communities residing in the neighbourhood of refugees.

The “incomplete programming”, the details of some activities, the limited use of monitoring as a management tool raise questions how and to which degree UNFPA aimed to ensure the quality in all aspects of its programmes and activities carried out and/or funded by UNFPA. The 7th CP shows that a lack of a functional quality assurance system can have multiple consequences. Some, if not all of the incompleteness in programming and in some details of the activities could have been avoided.

Monitoring should be an inbuilt management element of each intervention. A monitoring system should be used for decision making which is the responsibility of each individual officer. In cases where projects are managed by the partners, the project itself is dependent on the M&E system of the partner. However, it would be UNFPA’s role to observe whether a partner has an adequate monitoring system and to take action and support the partners when needed. This could be an example to assist partners in a sustainable, capacitating approach, focussing more on the institution than on individuals. In this light also analyses of finance and programme data should be part of routine, not limited and dependent on events like an evaluation exercise.

If it is considered to conduct a pilot, either with a specific programmatic or geographic focus, then it has to be first ensured that the pilot would be contributing to a particular national policy debate. And if so, then the design of such a pilot should ensure, before commencing, that the pilot has an added value for national policy and strategy makers, i.e. to be carried out at the right time and sequence to feed into national deliberations.

The UNFPA projects and to large extent also the components are still operating in programmatic isolation. Mutual benefits and linkages are better ensured in fluent communication and collaboration than through formalised coordination meetings. This is not to undermine the importance of regular coordination meetings within UNFPA and between projects, but should emphasise the responsibility of each staff member to be proactive and willing to link up on her/his own initiative with colleagues based on professional judgement and ambition, not dependent on personal preferences.
UNFPA continued work through a project approach, which slowed the process to think in programme terms. The high number of projects put a cumbersome burden to follow up the projects managerially and is likely to have caused higher transaction costs. A drastic reduction of numbers of projects and applying alternative modes of cooperation could make better use of funds and personnel. The preferred mode of cooperation would be a case by case decision, for example trainings and research could be rather subcontracted than having a project with research and training institutions.

Management of project staff, procurement, approvals and fund release by the UNFPA is highly bureaucratic and disbursement delays are reportedly longer than in other UN funded projects.

Some terms are often interpreted differently, as the term “decentralisation”. While formally decision making in the projects is decentralised to project directors (PDs) it frequently appears that this “decentralisation” is rather nominal while decision making stays largely in the hands of the UNFPA office with a varying degree of micro-management. Moreover, the management set-up through PDs is in reality risking undermining the ministries taking responsibility because projects are not necessarily incorporated into the existing systems, but often run as separate entities even if the PD is part of a ministry.

The National Professional Project Personnel (NPPP) are often, although not entirely, used for fulfilling administrative and organisational tasks. Even if working technically, the NPPPs seem rather be considered as an additional office staff and hereby acting on behalf of their colleagues, less so assisting in the sense of coaching their colleagues in the Ministries. In line with the UNFPA internal coordination and communication, the office could develop its “office culture” further from a commanding to a supporting culture. Hereby the NPPPs and the zila sub-offices should rather be in the forefront of decision making then to be executing decisions.

UNFPA has developed productive working relations with some national NGOs. Since the involvement of NGOs and Civil Society Organisations (CSO) was still rather small UNFPA might be missing out the perceptions and views of the civil society which UNFPA needs for its advice in national policy and strategy design. In its institutional capacity building efforts UNFPA could well include a focus on CSO including support in service provision and activities.

Raising awareness among families and households got high attention by various project activities. Notwithstanding the value of the variety of communication means, the personal interaction of households with home visitors of the various departments, organisations and institutions seem to be most appreciated by the households and influential, as stated by a variety of key informants and documents, which invites for a comparative qualitative operational study to verify objectively the added values of the various communication means.

The 7th CP had incorporated a wide range of issues and themes. The experience over the last year have shown that UNFPA’s investment were too thinly spread in respect to the capacity of UNFPA Bangladesh to make a clear difference with the required standard and state of the art. UNFPA might wish to concentrate and streamline its efforts to the most pressing and priority issues in the country (“what is most needed”), corresponding to priorities set by the GoB (“what is most wanted”) and in reflection to the mandate of UNFPA (“what we can do best”). The main recommendation confirm the view of UNFPA to refocus from training, procurement and awareness to institutional capacity, policy and strategic development while making sure that people in immediate need are assisted (through CSOs).

Fertility rate and population growth are still high and present a major challenge and threat in Bangladesh for the medium and longer term future. The evaluation team suggests to focus the Reproductive Health component on the reduction of Fertility until the capacity of the UNFPA is built up to adequately address RH more comprehensively, especially maternal health. Fertility reduction and a focussed support of the Gender agenda appear as they main issues to pursue in a consolidate approach.

Within and across these two main agendas 4 blocks could lead the strategic directions:

A: Institutional capacity building of the DWA in MoWCA and FP Directorate in MoH&FW
B: Advocacy on policy and political level to carrying the agendas of Fertility Reduction and Gender
C: Creation of a critical mass for change in attitude and behaviour and mainstreaming
D: Empowerment (including support to women’s needs as e.g. GBV victims/survivors)

Additional recommendations are provided for each of the blocks, as well as for accompanying mechanism (including the continuation of the productive contribution to the health sector debates and the SWAp pool), issues to be observed in design and implementation, the role of CSOs, the Sector Ministries/partner institutions, project and programme design, management and for UNFPA internally.
1 INTRODUCTION

1.1 DESCRIPTION OF 7TH COUNTRY PROGRAMME

The United Nations Population Fund (UNFPA) has been working in partnership with the Government of the People's Republic of Bangladesh (GoB) since 1974 through technical advisory services and financial support. So far, UNFPA has completed six country programme (CP) cycles, while it is currently carrying out its 7th CP (2006-2010). At the request of the GoB, the CP has been extended by an additional year, and will now be completed by 31 December 2011 in order to harmonise the next CP with the United Nations Development Assistance Framework (UNDAF), other United Nations (UN) agencies and the Joint Cooperation Strategy (JCS).

Bangladesh has made significant progress in pursuing many of the goals of the International Conference on Population and Development (ICPD) Programme of Action and the Millennium Development Goals (MDGs). The national development plans, i.e. the Poverty Reduction Strategy Paper (PRSP) and Five Year Annual Plans, focused on the general improvements in the quality of life of the Bangladeshi people and reductions in the number of poor people in the country. However, progress has been uneven, and socio-economic, geographical and gender inequalities have been widened. Especially, inequalities in access to quality reproductive health (RH) services, disparities in health outcomes and gender inequalities in many areas persist in the country. RH remains a particular concern in Bangladesh. While the country has been quite successful to reduce the fertility rate over the last decades from over 6, it is facing a pressing need to reduce its population growth, with its multiple effects including on maternal health. However, the current population growth is still too high and rather stagnant, although the total fertility rate (TFR) has restarted to decline and Contraceptive Prevalence Rate (CPR) to increase.

The 7CPs built on the experiences of earlier country programmes and reflects the ICPD agenda and the Beijing Plan of Action, the priorities of the UN common country assessment/United Nations Development Assistance Framework (CCA/UNDAF), the UNFPA multi-year funding framework (MYFF, 2004-2007) and UNFPA’s strategic plan (2008-2011). The CP has also taken into account the MDGs and PRSP targets. The programme intended to emphasise capacity development, service delivery and has a particular focus on the poor and vulnerable populations gender equality and empowerment of women, with special emphasis on gender-based violence (GBV). This programme also supports the health-sector SWAp and the Health, Nutrition and Population Sector Programme (HNPSP) through parallel funding as well as a small proportion of funds placed in the pool. The CP was designed to be nationally executed with the GoB, in close partnership with other UN agencies, NGOs and the private sector.

TABLE 2: UNFPA 7TH CP COMPONENTS

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Reproductive Health</th>
<th>Gender</th>
<th>Population &amp; Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1: Population and reproductive health strategies (the PRSP, MDG report, the SWAp and the population policy) are effectively translated into programmes, especially for the poor and vulnerable.</td>
<td>Outcome: Women and girls are supported and empowered to make decisions about their reproductive health and rights.</td>
<td>Outcome: A policy environment that promotes reproductive health and rights is created.</td>
<td></td>
</tr>
<tr>
<td>Outcome 2: Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreseen Budget</td>
<td>28.05 M US$ ($20.05 M regular, $8 M other resources)</td>
<td>7 M US$ ($5 M regular, $2 M other resources)</td>
<td>4.45 M US$ ($3.95 M regular, $0.5 other resources)</td>
</tr>
</tbody>
</table>

The results and resource framework (RRF) of the 7th CP identified the outcomes and outputs, indicators and resource requirements around three mutually re-enforcing programme components: i) Reproductive Health (RH), ii) Gender, and iii) Population and Development (P&D).

For the first time in Bangladesh, UNFPA, in consultation with the Government of Bangladesh) selected two zilas (i.e. Cox’s Bazaar and Sylhet) from two low performing divisions (Chittagong and Sylhet) based on the performance of some
RH indicators such as maternal mortality ratio (MMR), infant mortality rate (IMR), contraceptive prevalence rate (CPR) and antenatal care (ANC) utilisation rate, mean age of first marriage and female literacy rate. It was aimed to implement in these two zilas comprehensively the 7th CP interventions, while many of them are national in scope (advocacy, contraceptive security, SWAp (Sector Wide Approach)). The interventions in the zilas were supposed to be coordinated through two UNFPA sub-offices. Sixteen implementing partners (IPs) from twelve ministries, one NGO and an autonomous body (Bangladesh Garments Manufacturers and Exporters association (BGMEA)) are carrying out the activities. The Economic Relations Division (ERD) of the Ministry of Finance (MoF) has been the overall coordinating GoB agency for all UN agencies, including UNFPA.

Next to the CP, UNFPA Bangladesh engaged in high policy debates, facilitated by a contribution to the health SWAp pool, and in three joint programmes such as the Demand based RH commodity project (funded by the Canadian International Development Agency, recently concluded), Accelerating the reduction of maternal and neonatal mortality and morbidity (funded by the United Kingdom Department for International Development and European Union) and the UN-GoB Joint Programme on Violence Against Women in Bangladesh (MDG Spain fund).

1.2 **PURPOSE AND OBJECTIVES OF THE EVALUATION**

According to the UNFPA Evaluation policy, an end of programme evaluation is mandatory and should be carried out in the penultimate year of a CP. The evaluation is meant to identify and document the achievements of the CP, as well as challenges encountered, lessons learned and to contribute to the planning of the next cycle of UNDAF and the UNFPA CP.

1.2.1 **GENERAL OBJECTIVE OF THE EVALUATION**

The General objective of the evaluation is formulated in the TOR (Terms of Reference) as to **assess the achievement of the programme at the end of the programme cycle in terms of planned outcomes, outputs and strategies, the factors that affected or facilitated the achievement, and to compile lessons learned so as to contribute to the development of the next country programme cycle.**

1.2.2 **SPECIFIC OBJECTIVES**

The evaluation TOR required the evaluation to be retro-, as well as prospective and therefore to focus on an assessment of the **programmatic strategies. The following is listed in the TOR:**

i) **Assess the current status of achievements** *(i.e., results and impact)* of the 7th UNFPA CP based on established outputs and outcomes through:
   - Comparing the planned activities, outputs, and outcomes with actual results;
   - Comparing and analysing the baseline and end-line survey data/information from the two districts, as well as other studies and evaluations conducted during the current CP cycle;
   - Collecting additional information from the partners;
   - Determining the sustainability and impact of the programme achievements.

ii) **Assess the relevance and effectiveness** of the technical approach *(e.g. women support centre in responding to GBV)* as well as overarching CP strategies, i.e. capacity development initiatives *(training, TA support, study tours, etc.)*; BCC / advocacy strategies *(material development, policy dialogues, influence on the sector programme)*; number of IPs and district based approach toward achieving the CP outcomes and outputs.

iii) **Assess the effectiveness and efficiency** of the programme management, implementation, coordination and linkages between three main programme areas, partnership and monitoring.

iv) **Assess the efficiency** of the current programme approaches including so many IPs for implementation of the programme and coordination issues.

v) Based on the above analysis, identify **facilitating and constraining factors** affecting programme performance *(including management issues)* and document the **best practices and key lessons learned from the 7th CP implementation.**

vi) **Provide key recommendations/directions** for the 8th CP in the area of P&I, RH, and gender, incl.:
• **Strategic areas and issues** of potential UNFPA contributions to the new programming in 2012-2016 in line with the national priorities as well as in light of accelerating the progress toward MDGs and number of partnerships.
• Recommendations for UNDAF and preferred programme management modalities based on the lessons learned.

1.2.3 **Key Evaluation Criteria and Questions Identified in the TOR**

The evaluation TOR stated that the evaluation should focus on the specific objectives and aim to answer the specific questions. The Evaluation Team (ET) grouped these questions according to the evaluation criteria, in correspondence to the United Nations Evaluation Group (UNEG) evaluation norms and standards:

**Achievements**
• What is the current status of achievements of the stated outputs and outcomes as mentioned in the 7th CP RRF through the planned activities? What progress towards the outcomes has been made?

**Relevance, effectiveness**
• To what extent have the planned outputs contributed to achieving the outcomes?
• To what extent are the technical approaches and overarching strategies/capacity development strategies relevant and effective in achieving the outputs and outcomes.
• What is the effectiveness of the IPs in contributing to the outputs and outcomes? Are they well aligned and efficient to contribute to the outcomes?

**Efficiency**
• What is the efficiency of having so many partners? Are they appropriately and adequately contributing to the CP outcomes?

**Management systems (human resources, financial resources, systems etc)**
• How and to what extent has the programme management, implementation, coordination, linkages, partnership and monitoring and evaluation contributed to the effectiveness and efficiency of the programme?

**Impact, sustainability**
• No question was identified in the TORs.

**Lessons learned**
• What are the constraints and facilitating factors that affect achievement of the intended results including the effectiveness and ineffectiveness of the intended results? What are the key lessons learned from the 7th CP design and implementation? How and to what extent has the 7th CP leveraged the multi-bilateral projects funded by other donors and the support to HNPS through pool funding to maximise the effectiveness of the programme? What are the lessons learned from this?
• What is the linkage between the ongoing MNH programme and the CP and SWAp? How are the lessons learned from the joint programme used for strengthening the CP as well as the HNPS? What are the lessons learned from Joint programmes – partnership etc.?

**Key recommendations**
• What are the key recommendations that should be addressed in the design and implementation of the 8th country programme?

1.3 **Evaluation Organisation and Team**

The evaluation was carried out by a team of four colleagues with expertise reflecting the comments of the 7th CP. The team included a technical expert/evaluator for gender issues, a technical expert/evaluator for RH, a technical expert/evaluator for P&D and a public health expert.

The overall management of the evaluation remained with the Economic Relations Division (ERD) and UNFPA. The UNFPA country office was responsible for coordination, administrative and logistic support and served the ET as the first and main point of reference.
1.4 Methodology and Approach

1.4.1 Principles

The ET followed three main principles in its approach:

- aiming at maximising the probabilities of a consensus among stakeholders and that the evaluation will be owned by the Bangladesh partners and stakeholders;
- capitalisation from experiences gained, in particular in view of the recommendations for the next funding period;
- strategic, while practical, pragmatic and reality based.

1.4.2 Ethical Considerations

The interviews and meetings were set up by the UNFPA office after agreement with the ET on which partners and offices the ET should interact with.

Each interview, individual as well as group meeting, commenced with the introduction of the present ET members, the explanation of the purpose of the meeting and interview, the overall evaluation process and which steps took already place and which ones were still planned, how the meeting fitted into the evaluation process and how the information gathered during the interview would be used and even more so, how it would not be used.

The ET emphasised that accompanying representatives of UNFPA would not be present during the meeting to ensure confidentiality and optimise privacy.

After the introduction the interviewees were asked whether they had a question about the meeting and the evaluation. Written consents were not collected, but the interviewees asked whether the meeting can continue after the introduction.

The names of interviewees were collected, unless it appeared unpractical in a large group discussion. At the same time it was emphasised that the persons would not be quoted, but an annex would list a summary of people and organisations met.

This however implied the disadvantage that some verbal or written feedback by the ET to main actors was dismissed because the source of the information was not disclosed by the ET.

The meetings concluded with an opening for questions for the ET by the interviewees, followed by the repeated explanations on the next steps and how the information would be used and NOT used.

Depending on the physical space available for group discussions, the meetings took place with closed door or in the open. Some group meetings had to be held in presence of superiors or authorities of the interviewees (e.g. in one school peer meeting a teacher was partially present). Individual meetings were held throughout in an acoustically safe room. During the triangulation the settings were taken into account by the ET.

Attention was also given to conduct group discussions separated by gender, where possible – see also list of persons/organisations met and attention was also given to promote a free talk (women and girls were met by the (female) gender expert of the ET).

1.4.3 Key Stakeholder Involvement in the Evaluation Process

The ERD and UNFPA composed the Evaluation Management Committee whereby UNFPA managed the day to day support of the evaluation.

Key stakeholders included the GoB (ERD, Ministry of Health and Family Welfare (MoHFW) (Directorate General Health Services (DGHS), Directorate General Family Planning (DGFP), Information, Education and Motivation (IEM), National Institute of Population Research and Training (NIPORT)), Ministry of Women and Children Affairs (MoWCA), Bangladesh Bureau of Statistics (BBS), Ministry of Youth and Sports (MoYS), Ministry of Local Government, Rural Development and Cooperatives (MoLGRD), Ministry of Religious Affairs (MoRA), Ministry of Education (MoE), Ministry of Information (MoI), Ministry of Home Affairs (MoHA), Parliament Secretariat), UNFPA (UNFPA Dhaka office, Sylhet and Cox’s Bazaar suboffices), UN agencies (UNDP, UNAIDS, WHO, UNICEF), the University of Dhaka
(Department of Population Sciences), the BGMEA, Islamic Foundation and the Imam Training Academy, NGOs and the SWAp local consultative group (LCG). The key stakeholders were involved in the evaluation through several steps:

- As further outlined below the key stakeholders were invited to the inception meeting where the methodology of the evaluation was presented by the ET, discussed and adjustments made.
- Meetings were set up for interviewing the key stakeholders either individually or in a group.
- The workshop on the 4th of January had the agenda of a validation, i.e. preliminary findings were presented by the ET, further discussed by the key stakeholders in working groups, presented to the plenary and included in the report.
- Further, the draft report was disseminated among the key stakeholders and their comments included in the final report.

1.5 **TOOLS AND MEANS**

The ET utilised a variety of tools for this exercise:

- TORs evaluation objectives and questions;
- 7th CP Results and Resource Framework;

The TOR for the evaluation explicitly required the evaluation team to use primarily the RRF and to describe the measurable performance indicators or standards of performance that would be used to assess progress towards the attainment of results. As further explained below, the RRF is of limited use for the evaluation. In order not to dismiss the efforts and investments by UNFPA unfairly, the ET concentrates much of its discussion in the following chapters on activities and processes. Outputs and outcomes are addressed as far as the RRF limitations allow. In this light, even with non-conclusive RRF objectives and indicators, the ET did not introduce new benchmarks or alike, but aimed at capturing the spirit and intention of an objective or indicator and commented against what the ET understood as the intention of the RRF.

It is not rare that RRFs or log-frames are inconsistent to some extent. Instead of utilising indicators or benchmarks which were not known prior to the evaluation (which of course would not be fair to the implementers) the closest alternative for an ET is aiming at understanding the intention, use it as a reference and verify in interviews to minimise uncertainties and doubts.

At the same time the ET discussed internally thoroughly and included in the report those assessments which found agreement and consensus among the ET members.

- Quantitative and qualitative information collected through the review of an extensive list of documents, semi-structured interviews and group discussions using a guiding questionnaire in Dhaka with stakeholders and Implementing Partners (IPs) and during the visits to the zila Sylhet and Cox’s Bazaar.
- Primary data collected from end-line survey (and baseline survey), as far as available;
- Triangulation of the information;
- Validation workshop/meeting.

1.6 **EVALUATION PROCESS**

The TOR, the briefing meeting in UNFPA and the inception meeting emphasised a strategic character of the evaluation. Therefore the evaluation required a wider range of consultations and visits and interviews in the two zilas and a workshop which served to receive feedback to presented preliminary

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2 See Annex 12: Inception meeting 10 December 2010
3 See Annex 9: List of persons and organisations met/sites visited
4 See Annex 7: Validation workshop 04 01 2011
5 See Annex 10: List of documents reviewed
6 See Annex 8: Guiding themes and questions
findings aiming at increasing the options for exchange with the main stakeholders and at allowing space for self assessments as well as formulating suggestions to observed weaknesses and/or gaps.

1. The Terms of Reference was used as the basis of the evaluation.
2. A briefing meeting with UNFPA took place on the 5th December, followed by the inception meeting with GoB, DPs, and key stakeholders of the national level on the 8th of December. The evaluation questions and process was discussed with the partners. According to the suggestions made in the meetings, revisions were made accordingly.
3. The review of documents, from the 5th December onwards (and even prior to the official commencement of the evaluation), included numerous project proposals, progress reports, studies and GoB national documentations incl. PRSP, HNPS. The review of the documents guided in the identification of references for the evaluative criteria in the assessment of the progress towards the attainment of results.
4. Semi-structured interviews using a guiding questionnaire with key informants, group discussions and direct observations. The questionnaire rather guided the conversations than being a list of “tick off” boxes. The interviews explored qualitative information for triangulation merging with the quantitative data of documents and reports. The ET left substantial space for the interviewees and groups to freely express themselves and add additional points. Next to the interviews of managerial and implementing key stakeholders, the ET had to apply a pragmatic approach in its sampling procedures. UNFPA facilitated the appointments and logistic arrangements based on the request of the ET to meet in each of the two districts at least one health facility of each level in the zila, at least two school peer and youth groups, a urban health facility, a tea garden factory, at least one textile factory health centre (in Dhaka), at least one women support centres, a fistula centre, home visitors and interventions of partner Ministries. The main selection criteria, UNFPA inevitably had to use (due to the short available time and the long list of people and institutions to be met), were logistic considerations (travel time, opening time, distance and availability of staff, peers, patients etc). The ET split into subgroups depending itinerary and sequence of meetings and site visits.

**Dhaka:**

- GoB: ERD, MoHFW (DGHS, DGFP, IEM, NIPORT), MoWCA, MoP - Bangladesh Bureau of Statistics, MoYS, MoLGRDC, MoRA, MoE, MoI, MoHA, MoLE, Parliament Secretariat
- University of Dhaka - Department of Population Sciences,
- BGMEA
- Islamic Foundation, Imam Training Academy
- UNFPA Dhaka office, Sylhet and Cox’s Bazaar suboffices
- UN: UNDP, UNAIDS, WHO, UNICEF
- SWAp local consultative groups: all members had been invited and only a World Bank representative appeared to the group meeting
- NGOs: meeting in a group

**Sylhet and Cox’s Bazar: 12. – 23.12.**

- Poor and vulnerable population – groups; youth groups, patients, victims/survivors, guardians, teachers, religious leaders
- NGO interventions
- Zila departments of line ministries (MoYS, MoLGRDC, MoE, MoI, MoHA) including Civil Surgeon’s and Family Planning (FP) offices, DOWCA
- Implementation/service deliveries like health facilities on all upazila level; Women Support Centres, Fistula Centres, youth clubs, schools, refugee camps
- UNFPA sub- offices

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7 See Annex 10: List of documents reviewed
8 See Annex 9: List of persons and organisations met/sites visited
9 See Annex 8: Guiding Themes and Questions
● Islamic Foundation, Imam Training Centre
● Tea Garden

5. The triangulation of information was done partially ongoing during the exercise and more systematically upon return of the ET from the visit to the Zilas.

6. The validation workshop (4th January) verified the preliminary findings by the ET and proposed suggestions and some recommendations for the next CP

7. A short debriefing meeting on the 4th January 2011 at UNFPA closed the physical presence of the ET in UNFPA.

8. The draft report was submitted on the 5th January 2011.

9. Comments on the draft were incorporated for the Final report.

1.7 MAIN LIMITATIONS AND CONSTRAINTS

Limitations of the evaluation derived from

● the short time frame allocated for a strategic evaluation, in particular in respect
  - to the high number of IPs,
  - to the wide range of target groups,
  - the high number and diversity of interventions within and outside the three components;
● the MTR took place only a year ago, i.e. in November 09, which allowed insufficient time to see an effect of the utilisation of the MTR’s recommendations;
● the composition of the team did not include a finance expert;
● the evaluation during a high peak of holiday period of UNFPA and non-UNFPA staff;
● limited monitoring and financial data from UNFPA were available.

A main constraint was posed by the high number of UNFPA staff taking annual leave during the evaluation process, which in some cases led to minimal time allocated to the evaluation.

As stated on several occasions in the report, there are no data available, including the preliminary data of the endline survey which the ET received, that could make a distinction between UNFPA’s effect and results and those of other actors. This is not necessarily a shortcoming because it is indeed desired to reduce parallel systems and to rely on a common/governmental information system. In consequence of course it is not possible to relate outcomes to a particular actor. A well designed UNFPA monitoring system could have provided data on input and output, possibly also on some outcomes. In absence and/or non use of such a monitoring system, the ET is stating tendencies, but cannot conclude precisely how and to which extent changes can be attributed to UNFPA.

Attention was also given to report gender specific, as far as this was possible and data available - the ET cannot quote aggregated data because they are not available.

1.8 REPORT STRUCTURE

The structure of the report follows the requirements as defined in the TORs.

The first part provides a concise introduction to the 7th CP of UNFPA and to the evaluation, followed by the chapter on findings and conclusions.

The analyses of the RRF for the 7th UNFPA CP Bangladesh leads to a brief summary of the progress and achievements, presenting the reference for the evaluation criteria. In an operational review a division of the report by the three UNFPA components facilitates capturing the recommendations for further use. The emphasis of a strategic evaluation lies rather in capturing the overall experiences and lessons for carrying the agenda further with a national and nation-wide view. Therefore separate sections elaborate on Relevance, Effectiveness, Efficiency, Impact, Sustainability, Management System, Harmonisation and Alignment for the following reason:

● It is state of the art generally applied in evaluation reports
Since this evaluation was requested to have a strategic focus, the operational details of each component are relevant as far as they provide the indications for the 8th CP strategy.

Reporting based on evaluation criteria is usually perceived more reader and user friendly.

The structure was proposed by the ET in the inception report and agreed by ERD and UNFPA. The possible disadvantages of using this structure, like some repetitions and the risk that the thread might get lost, are recognised by the ET and minimised as far as possible, however cannot be eliminated entirely without losing out on clarity.

The third part recapitulates key strategic lessons learned and puts forward recommendations.
2 FINDINGS AND CONCLUSIONS

2.1 RESULTS AND RESOURCE FRAMEWORK

The TOR emphasise that the evaluation should closely refer to the (RRF) – see table below. Therefore this, additional, chapter on the RRF is included, highlighting the main methodological observations by the ET on the RRF, however limited to some key issues.

The 7th CP RRF follows the UNFPA format, using one goal, several outcomes and outputs with selected related indicators. The format does not foresee output and outcome corresponding assumptions or risks and it does not specify the sources of the data/information for the indicators.

Most of the following comments were already made by the MTR (conducted during November 2009). The ET largely concurs with the observation made by the MTR in respect to the RRF. The MTR acknowledged the relative short remaining time-period of the 7th CP, but recommended adjustments of the RRF without major directive changes. The UNFPA team attempted to address the RRF\textsuperscript{10}, however the revision of the RRF took undue long time and is still not officialised. No conclusive reasoning was given to the ET for this delay. Since the revised RRF, improved in consistency and logic, although still contains inconsistencies, is not in use by the office, the ET refers to the original RRF. It would not be fair to the Country Office (CO) and the partners to review against the revised RRF.

Goal of 7th CP

Indicators for the goal are not identified in the RRF. The phrasing of the goal (“to contribute to improving the reproductive health status of the population”) defines the goal on a high and wide ranged level, but specific for RH. By specifying RH, the non-RH elements of gender and P&D would therefore be excluded.

RH outcome 1, outputs and their indicators

Both outputs (1. “Increased access to improved sexual and reproductive health information and services” and 2: “Increased demand, especially among the poor and vulnerable, for reproductive health services.”) in the RH component are essential elements in carrying the RH agenda and address both, the supply as well as the demand side. However they do not present contributing elements to achieve their outcome (Outcome 1: “Population and reproductive health strategies (the PRSP, MDG report, the SWAp and the population policy) are effectively translated into programmes, especially for the poor and vulnerable”). To the contrary, national policies and strategies should serve to ensure higher accessibility to and demand for RH services.

The targets of the 1st output indicator (“Deliveries by skilled birth attendants increased from 13% to 20% by 2010”) and the outcome indicator (“The proportion of births attended by skilled health personnel increased from 13% to 50%”) are inconsistent, whereby the output indicator appears to be more realistically achievable. The fourth indicator of output 1 (“In-country capacity in forecasting, procuring and distributing reproductive health commodities strengthened”) is vaguely worded, leaving doubts how this indicator will be measured.

RH component outcome 2, outputs and their indicators

The outcome (“Outcome 2: Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS”) refers to two elements, knowledge and self protection against STI and HIV/AIDS. One output (“Output 3: Sexual and reproductive health needs and the education of young people addressed”) is phrased as a wider concept and the knowledge elements is overlapping with the outcome. While the other output (output 4 “Improved awareness of and prevention of RTIs, STIs and HIV/AIDS among young people and high-risk groups”), is limited to RTI, STI and HIV, but includes high risk groups. It is not clear how the high risk groups relate to the outcome, which addresses only young people.

The first output indicator (“National adolescent reproductive health strategy and action plan for young people developed”) does not measure the achievement of the corresponding output (“Sexual and reproductive health needs and the education of young people addressed”).

\textsuperscript{10} See Annex 5: 7th CP revision after MTR November 2009

\textsuperscript{11} The revised RRF is improved in its logic, although still contains inconsistencies
While objectives and their indicators are largely limited to knowledge and awareness, at the same time behaviour change was expected from commercial sex workers in brothels (and their clients). The different degree of impacting is not well explained or expressed.

**Gender outcome, outputs and their indicators**

The discrepancies mentioned under the RH component are even more striking in the gender component, whereby the outcome (“Rights of women and girls promoted and gender equity enhanced”) is on a higher level than the outcome (“Women and girls are supported and empowered to make decisions about their reproductive health and rights”). Both outcome indicators (National mechanisms in place to monitor and reduce gender-based violence; Civil society partnerships actively promote gender equity, women’s and girls’ empowerment and reproductive rights) are difficult to measure and their specificity and level of achievement hard to define. Also, the combined indicators provide insufficient information to allow a statement on the achievement of the output and outcome.

**Population and Development component outcome, outputs and their indicators**

The linkage between outcome (“A policy environment that promotes reproductive health and rights is created”), output 1 (“output 1: Population and gender concerns integrated into national and sectoral plans” and output 2 (“Improved analysis and utilisation of data disaggregated by age, sex, economic status and location”) is more logic than in the other two components.

**General comments on the RRF**

The levels of success/targets are inconsistently identified in the indicators and most do not specify the levels strived for. It is quite acceptable that baseline values cannot be referred to during the design of a RRF at a time when baseline values might not be known and it is very possible to await a baseline survey to determine the values. However this should be mentioned in the RRF, which would permit consistency and clarity of the RRF (e.g. “increase by x percentage over baseline”). Alternatively, the RRF could also refer to an updated RRF to be finalised after the baseline survey, provided such an update is planned for and subsequently serves as the reference document.

Some organisations’ format emphasise the formulation of "SMART" (S Specific; M Measurable; A Achievable, R Relevant, T Time-bound) objectives, other of "SMART" indicators. However one of the two options should be consistently applied in the same framework. In the first case, since objectives already include a timeframe, baseline and target values, often indicators are formulated as a variable. In the second option, the variable is completed with a timeframe, a baseline and target values. Consequently, these indicators are more specific, including information about target groups and what needs to be achieved for these target groups.

It appears that the 7th CP RRF intended the second option, however this was incompletely applied. Even distinguishing between “direct” and “indirect” indicators (or proxy-indicators) they have to refer to the outcome/output content with sufficient specificity and relevance to allow an assessment of the degree of achievement. Most indicators cannot be considered SMART in the context of this 7th CP RRF and their respective outputs and outcomes.

The linkages between outputs and outcomes, particularly in the RH and gender component, are insufficiently expressed and the levels of “hierarchy” appear in a reversed order.

The UNFPA format does not require the identification of assumptions and/or risks, i.e. the factors which cannot be influenced by the programme/projects are not specified, leaving an unclear space for interpretation by the reader and user of the RRF.

**Concluding remarks**

A key – informant described the RRF as an illogical framework to which the ET would agree to. As a consequence, although the TOR specifically states that the evaluation should primarily refer to the RRF, the RRF does not provide sufficient clarity and consistency to serve as the main guiding document.

Even more so, the RRF could not provide the UNFPA team with sufficiently clear guidance, direction or vision for the period of the 7th CP as further elaborated below.

Comments on the evaluation draft report argued that “The evaluation team used the original RRF that was attached to the CPAP. However, it was mentioned to the evaluation team that the weakness were
identified by the DOS / HQ and also during the MTR and initiative has been taken to review and revised some of the outputs and indicators. The revisions have been shared with the evaluation team.” However, as stated above, the revision of the RRF is still not official, not yet used as a reference by the UNFPA office and was shared with the ET only half way through the evaluation exercise. Therefore the ET could not fairly use the revision as a reference for the evaluation.
**Table 3: Outcomes, Outputs, Indicators**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Outcome Indicators</th>
<th>Outputs</th>
<th>Output Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reproductive health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome 1:</strong> Population and reproductive health strategies (the PRSP, MDG report, the SWAp and the population policy) are effectively translated into programmes, especially for the poor and vulnerable</td>
<td>● The contraceptive prevalence rate increased from 58% to 70%.&lt;br&gt;● The proportion of births attended by skilled health personnel increased from 13% to 50%.</td>
<td><strong>Output 1:</strong> Increased access to improved sexual and reproductive health information and services.&lt;br&gt;<strong>Output 2:</strong> Increased demand, especially among the poor and vulnerable, for reproductive health services.</td>
<td>● Deliveries by skilled birth attendants increased from 13% to 20% by 2010&lt;br&gt;● Percentage of women accessing antenatal care increased by 10% per year in pilot areas&lt;br&gt;● Number of clients receiving family planning services in pilot areas increased by 15%&lt;br&gt;● In-country capacity in forecasting, procuring and distributing reproductive health commodities strengthened.&lt;br&gt;● Percentage of clients accessing services in UNFPA-supported service delivery points increased by 20%&lt;br&gt;● Voucher scheme piloted in one upazila (subdistrict) covers 50% of poor pregnant mothers.</td>
</tr>
<tr>
<td><strong>Outcome 2:</strong> Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS.</td>
<td>● Proportion of the population aged 15-24 with comprehensive knowledge of HIV/AIDS.</td>
<td><strong>Output 3:</strong> Sexual and reproductive health needs and the education of young people addressed.</td>
<td>● National adolescent reproductive health strategy and action plan for young people developed.&lt;br&gt;● 20% of service delivery points offer information and services for young people&lt;br&gt;● Percentage of young people knowledgeable about the transmission and prevention of HIV and STIs increased from 48% to 60%&lt;br&gt;● Percentage of commercial sex workers using condoms during last intercourse increased by 20% in two brothels</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome:</strong> Women and girls are supported and empowered to make decisions about their reproductive health and rights</td>
<td>● National mechanisms in place to monitor and reduce gender-based violence.&lt;br&gt;● Civil society partnerships actively promote gender equity, women’s and girl’s empowerment and reproductive rights.</td>
<td><strong>Output:</strong> Rights of women and girls promoted and gender equity enhanced.</td>
<td>● Proportion of community leaders and decision makers sensitised through UNFPA programmes who promote gender issues increased to 20%.&lt;br&gt;● Reliable data on gender-based violence becomes available.&lt;br&gt;● Male coalition established that supports women’s rights and condemns violence against women.</td>
</tr>
</tbody>
</table>
## Population and development

### Outcome:
A policy environment that promotes reproductive health and rights is created.

- Reproductive health and gender concerns incorporated into the PRSP, SWAp and MDG reports.
- Strategies are in place to delay age at marriage.
- Population-related data from national databases disaggregated by age, sex and poverty level used to monitor national development plans.

### Output 1: Population and gender concerns integrated into national and sectoral plans.

- Harmful practices (early marriage, dowry, gender-based violence) analysed and user-friendly publications disseminated.
- The Government is assisted in developing an action plan for the population policy.

### Output 2: Improved analysis and utilisation of data disaggregated by age, sex, economic status and location.

- Poverty profiles by age and sex established in pilot areas.
- Digital mapping utilised for reproductive health-related activities.
2.2 \textbf{Achievements of the Country Programme}

For easier reading, due to the high number of projects, the completed and ongoing interventions are summarised in tables (see below), grouped into the three different components, corresponding to the various outcomes and outputs. As explained above, the discrepancies in the RRF do not allow to picture well clear linkages between the projects and their achievements and the RRF outputs.

\begin{figure}[h]
  \centering
  \includegraphics[width=0.5\textwidth]{semi_structured_interviews.png}
  \caption{Semi-Structured Interviews}
\end{figure}

\begin{figure}[h]
  \centering
  \includegraphics[width=0.5\textwidth]{group_discussion.png}
  \caption{Group Discussion}
\end{figure}
### TABLE 4: 7TH CP ACHIEVEMENTS REPRODUCTIVE HEALTH - COMPONENT

<table>
<thead>
<tr>
<th>Reproductive Health</th>
<th>Projects</th>
<th>IP</th>
<th>Interventions/Activities</th>
<th>Achievements/Progress Information retrieved from (Annual) Reports (see Annex 10: List of documents reviewed)</th>
<th>Location</th>
<th>Funds &amp; Donors</th>
<th>Administrator/Programme Component Manager (PCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capacity development for RH¹²</td>
<td>DGHS</td>
<td>Training on FP methods, EOC and CSBA, fistula surgery and management, VAW, continuous medical education, advocacy, procurement of supplies, equipment and logistics</td>
<td>i) CSBAs trained &amp; performed deliveries ii) Facilities performing fistula repairs, rehabilitation centre established &amp; budget for construction of National Fistula Centre iii) Voucher scheme in three Cox’s Bazaar upazilas</td>
<td>All over Bangladesh, with special focus at Cox’s Bazaar and Sylhet districts.</td>
<td>UNFPA, government contribution in kind.</td>
<td>Prof. Dr. Kh. Md. Shefyetullahm DG, DGHS.</td>
</tr>
<tr>
<td></td>
<td>RH intervention through DGFP</td>
<td>DGFP</td>
<td>Strengthen capacity of 70 MCWCs and UH&amp;FWCs in Sylhet and Cox’s Bazaar, trained service providers, SRH services for women, male &amp; adolescent, &amp; cervical and breast cancer screening, training on EOC</td>
<td>i) Services providers including Medical Officers trained on obstetrics, clinical contraception, RTI/STI and HIV/AIDS case management VIA, Gender, Youth friendly Services, Male involvement and Management of VAW with IPC ii) Increased performance of all services including deliveries, CS,</td>
<td>All over Bangladesh, with special focus at Cox’s Bazaar and Sylhet districts.</td>
<td>UNFPA (both from regular and multi-bilateral); Government contribution in kind.</td>
<td>Dr.A.K.M. Mahabub Rahman, PD-Incharge</td>
</tr>
</tbody>
</table>

¹² Subsequent to the draft report, the UNFPA office provided additional information, which had not been conveyed in reports or interviews during the evaluation exercise. The additions are the following (although could not be verified by the ET):

......development of strategic direction documents for strengthening midwifery services in Bangladesh. This government approved document (supported jointly by UNFPA and WHO) is the milestone document to guide the development of midwifery cadres as per ICM standard in Bangladesh for the first time in its history. As per the strategic direction, UNFPA has been supporting the in-service midwifery training (6 months) for the existing nurse midwives. The curriculum was also developed for this purpose. Furthermore, based on the lessons learned from the CSBA programme, UNFPA has been strongly advocating for the two-fold strategy to increase skilled birth attendance which is now reflected in the next health and population sector programme (SWAP) strategic document. It should also be noted that the strong advocacy efforts made by UNFPA through H4 partnership (i.e., helped the GoB in developing national action plan) resulted in the prime minister’s commitment when addressing the 65th General Assembly of the UN on progress in attaining the MDGs: - “Doubling the percentage of births attended by a skilled health worker by 2015 (from the current level of 24.4%) through training an additional 3000 midwives, staffing all 427 sub-district health centres to provide round-the-clock midwifery services, and upgrading all 59 district hospitals and 70 Mother and Child Welfare Centres as centres of excellence for emergency obstetric care services. Bangladesh will also reduce the rate of adolescent pregnancies through social mobilization, implementation of the minimum legal age for marriage, and upgrading one third of MNCH centres to provide adolescent friendly sexual and reproductive health services. Bangladesh will halve unmet need for family planning (from the current level of 18%) by 2015; and ensure universal implementation of the Integrated Management of Childhood Illness Programme”. This is highlighted in the foreword of the next SWAP. This is the achievement which has the lasting impact.”
# Reproductive Health

<table>
<thead>
<tr>
<th>Projects</th>
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<th>Interventions/Activities</th>
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<th>Administrator/Programme Component Manager (PCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening IEM Unit.</td>
<td>DGFP / IEM</td>
<td>Awareness raising, campaign, advocacy, training, communication materials development</td>
<td>National Communication Strategy and action plan developed; draft IEM Unit is activated.</td>
<td>All over Bangladesh, with special focus at Cox’s Bazaar and Sylhet districts.</td>
<td>UNFPA, government contribution in kind.</td>
<td>Mr. Ganesh Chandra Sarker, Director (IEM) &amp; Project Director</td>
</tr>
<tr>
<td>Urban health project</td>
<td>Ministry of LGRD</td>
<td>BCC and services on safe motherhood, promote FP, RTI/STI, HIV/AIDS through group meetings, lobbying and advocacy.</td>
<td>i) Services provided, almost one third of whom were poor and provided free treatment</td>
<td>Six city corporations and 5 municipalities</td>
<td>UNFPA, government contribution in kind.</td>
<td>Mr. Abu Bakr Siddique, Project Director, UPHCP II</td>
</tr>
<tr>
<td>Ensuring comprehensive RH services in Nayapara and Kutapolang areas (Intervention for Rohingya Refugees).</td>
<td>RTMI</td>
<td>SRH awareness, advocacy, and services including normal deliveries and contraceptives</td>
<td>Number of contraceptive users and facility based deliveries increased</td>
<td>In Cox’s Bazaar Zila.</td>
<td>UNFPA</td>
<td>Dr. Humaira Begum, Project Coordinator – IPD</td>
</tr>
<tr>
<td>Life skill based reproductive health education for in-school youth and adolescent.</td>
<td>Directorate of Secondary and Higher Education of Ministry of Education</td>
<td>Life skill training, enter-education &amp; referral for ASRH services</td>
<td>Teachers are provided with master trainers training and they in turn conducted TOT for the peer educators. The peer educators conduct day long sessions for the peers.</td>
<td>Focused at Cox’s Bazaar and Sylhet districts.</td>
<td>UNFPA</td>
<td>Prof. Dr. Md. Sirazul Hoque Director (P&amp;D) &amp; PD</td>
</tr>
<tr>
<td>Youth empowerment through life skills education and livelihood opportunities project</td>
<td>Departmen t of Youth Development under the Ministry of Youth and Sports</td>
<td>Life skill training, livelihood training, enter-education &amp; referral for ASRH services, ASRH strategy and action plan developed.</td>
<td>Developed a life skill module for young people, and booklet and flip chart for facilitations sessions. These are prepared through participatory workshops.</td>
<td>t Cox’s Bazaar and Sylhet districts.</td>
<td>UNFPA</td>
<td>Md. Mizanur Rahman, Deputy Secretary and PD</td>
</tr>
<tr>
<td>Projects</td>
<td>IP</td>
<td>Interventions/Activities</td>
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<tr>
<td>HIV/AIDS projects with high risk groups</td>
<td>DGHS / NASP/CA RE &amp; Bnadhu</td>
<td>Advocacy, research, awareness raising, promotion for condom use and condom distribution, VWA, human rights, support self health groups,</td>
<td>Partnership Forum on HIV and Sex Work Issues is established at the national level</td>
<td>Intervention on CSW at Tangain and Mymensingh, Na that for transgender persons in Dhaka.</td>
<td>UNFPA</td>
<td>component manager is – DG, DGHS and focal person is Dr. Md. Abdul Wadud, LD, NASP</td>
</tr>
</tbody>
</table>
### Table 5: 7th CP Achievements - Gender Component

<table>
<thead>
<tr>
<th>Gender</th>
<th>Projects</th>
<th>IP</th>
<th>Interventions/Activities</th>
<th>Achievements/Progress</th>
<th>Location</th>
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<th>Administrator/Programme Component Manager (PCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Promotion of Gender Equality and Women’s Empowerment</td>
<td>DWA of MoWCA</td>
<td>Policy dialogue, community mobilisation, workshop, study tour, mobilisation against VAW rally, meetings, support to the victims of violence, formation of men engaging network</td>
<td>i. Part time field motivators are employed at the grass root level as a vehicle for change and collecting information on VAW cases, and as referral points ii. Produced series of training manuals iii. Engaged men and boys to reduce VAW iv. Women Support Centre at Sylhet and Cox’s Bazaar vi. Workshops, trainings and dialogues</td>
<td>Focused in Sylhet &amp; Cox’s Bazaar district. Some activities in Bhola and Kurigram, and some at National level.</td>
<td>UNFPA</td>
<td>Mr. Nizamuddin Al-Hussainy, DirectorDWA and PD</td>
</tr>
<tr>
<td></td>
<td>Advocacy on Reproductive Health and Gender</td>
<td>Dept. of Mass Communication of Ministry of Informat’n</td>
<td>Mass campaign, mass communication, utilisation of local means of communication - folk music session, film show, folk drama; sensitising media people and the information officers</td>
<td>i. Introduced culturally oriented approach (folk singers are in place) ii. Brought women to public place to expose them to mixed audience iii. Utilised mainstreamed population communication unit for mass campaign</td>
<td>All 64 districts around Bangladesh with special focus on Sylhet and Cox’s Bazaar</td>
<td>UNFPA</td>
<td>Mr. Tasir Ahmed, DG and PD</td>
</tr>
<tr>
<td></td>
<td>Involvement of Religious leaders in Human Resource Development</td>
<td>Ministry of Religious Affairs</td>
<td>Orientation training, refreshers’ orientation through Islamic Foundation, Imam training Academy, Hindu &amp; Buddhist Religious Welfare Trust, involving religious institutions in orienting/providing training to religious leaders</td>
<td>i. Multi-faith leaders conference to promote women’s rights organised; ii. Course outline for Imam Training Academy developed iii. Religious institutions, like, Islamic Foundation, Imam Training Academy, Hindu &amp; Buddhist Welfare Trust, etc.</td>
<td>All 64 districts with emphasis to Sylhet and Cox’s Bazaar</td>
<td>UNFPA</td>
<td>Mr. Kamal Uddin Ahmed, Joint Secretary and PD</td>
</tr>
<tr>
<td>Advocacy on Reproductive Health &amp; Gender Issues through the training Institutes of the Ministry of Home Affairs</td>
<td>Ministry of Home Affairs</td>
<td>Research and studies on gender and GBV Developing training curriculum, handbooks and BCC materials Capacity building (i.e., training of law enforcing agencies) Formation of Project Steering Committee (PSC) and Project Implementation Committee (PIC) and solicited top level commitment Regional training Orientation workshops for senior level officials Consultation meetings between LEAs and civil society, NGOs and community people</td>
<td>i. Training curriculum and training related materials were developed and published. ii. HIV/AIDS strategy developed for law enforcement agencies ii. A series of orientations/workshops/trainings courses were organised where 73,420 members of the LEAs participated iv. Training provided to 30 Imams on gender issues and preventing VAW v. 15 training institutes, under the MOHA observed International Women Day, World Population Day and World AIDS Day</td>
<td>All 64 districts with emphasis to Sylhet and Cox's Bazaar</td>
<td>UNFPA and DFID</td>
<td>Mr Didar Ahmed DS (Admin), Mr S M Monirul Islam DS (Admin) and Mr Md. Abu Taleb Molla DS (Admin)</td>
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</tr>
<tr>
<td>Capacity building initiatives for law enforcing agencies to promote reproductive health reproductive rights, and prevent gender based violence and HIV/AIDS</td>
<td>Ministry of Home Affairs</td>
<td>Research and studies on gender and GBV Capacity building (i.e. training of law enforcing agencies) Regional training Orientation workshops for senior level officials Consultation meetings between law enforcing agencies and civil society, NGOs and community people</td>
<td>i. Training curriculum and training related materials published and distributed ii. Gender in curricula integrated of all training institutes that impart specialised training to members of law enforcing agencies iii. Series of orientations/workshops/trainings courses organised with participation of 41,829 members of the law enforcing agencies</td>
<td>All 64 districts with emphasis to Sylhet and Cox’s Bazaar</td>
<td>UNFPA</td>
<td>Mr. Belayet Hossain Talukdar, PD&amp; Deputy Secretary, MOHA</td>
<td></td>
</tr>
<tr>
<td>Promotion of reproductive health, reproductive rights, gender equality and prevention of HIV/AIDS in Tea Garden Communities</td>
<td>Dept of Labour, Ministry of Labour Employm’t</td>
<td>Community group meeting, utilisation of local means (drama, film show, cultural events); primary health care, contraceptive supply</td>
<td>i. Knowledge increased on RH,RR, HIV/AIDS ii. Service centres in place and provide regular services</td>
<td>Tea garden communities in Sreemangal</td>
<td>UNFPA</td>
<td>Md. Mozammel Hossain, PD and Deputy Director of Labour</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 6: 7th CP ACHIEVEMENTS - POPULATION AND DEVELOPMENT COMPONENT

<table>
<thead>
<tr>
<th>Projects</th>
<th>IP</th>
<th>Interventions/Activities</th>
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<th>Administrator/Programme Component Manager (PCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Involvement of Parliamentarians in Reproductive Health, Rights, Gender Issues and Development (IPRGD)</strong></td>
<td>Parliament Secretariat</td>
<td>a. Formation of Project Steering Committee and solicited top level commitment; b. Day-long orientation workshops for Parliamentarians; c. Day-long orientation workshops for Parliament Secretariat Officials; d. Round Table Discussion:</td>
<td>Two years under caretaker government, the Project Steering Committee is formed in July 2009 under the leadership of the Parliament Secretary. Two day-long workshops were organized for MPs on population, RH, RR, gender and HIV/AIDS concerns integrated into national and sectoral plans. Round table discussion organised on P&amp;D: Role of MPs as Change Agent; attended by 35 MPs.</td>
<td>Bangladesh Parliament Secretariat, with few workshops at local level</td>
<td>UNFPA</td>
<td>Md. Wahidul Islam Khan, Bangladesh Parliament, Deputy Secretary</td>
</tr>
<tr>
<td><strong>Integration of Population and Gender into National and Sectoral Planning (IPGNSP)</strong></td>
<td>Planning Commission</td>
<td>1. Research/Studies and their Dissemination/Seminar, 2. Policy Dialogue strategy/policy brief, 3. Capacity Building of Govt. officials by orientation and trainings.</td>
<td>Conducted two research on issues on gender and on partnership with civil society for promoting RH and Gender. Conducted four policy dialogue on issues like climate change, community support, programme integration, and reducing TFR. Also</td>
<td>Senior and mid-level planners, mainly in the capital, with participation of some senior staff at the district level</td>
<td>UNFPA</td>
<td>Niru Shamsun Nahar, Joint Chief (Health Wing), SEI Division, Planning Commission &amp; PD INGNSP Project</td>
</tr>
</tbody>
</table>
### Population and Development

<table>
<thead>
<tr>
<th>Projects</th>
<th>IP</th>
<th>Interventions/Activities</th>
<th>Achievements/Progress</th>
<th>Location</th>
<th>Funds &amp; Donors</th>
<th>Administrator/Programme Component Manager (PCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for Policy Planning and Program Research for Population Development.</td>
<td>NIPORT</td>
<td>1. Research/Studies and their Dissemination/ Seminar, 2. Policy Dialogue strategy/policy brief, 3. Capacity Building of Govt. officials by orientation and trainings.</td>
<td>All planned researches/studies such as baseline and end line study, dowry, GBV, maternal health and morbidity study, commodity projection conducted. Training for upazila on gender RH rights, population and development.</td>
<td>National Institute for Population Research and Training (NIPORT)</td>
<td>UNFPA</td>
<td>Dr Awwal Bijat</td>
</tr>
<tr>
<td>Strengthening the Capacity of BBS in Data Collection and Analysis Using GIS Maps</td>
<td>Bangladesh Bureau of Statistics (BBS)</td>
<td>1. Capacity Building of Govt. officials by orientation and trainings. 2. Prep of GIS map 3. Construction of thematic maps on the population issues.</td>
<td>Capacity building of the BBS staff on GIS and gender disaggregated data is completed. The digitized GIS maps up to the mouza level are also completed, and server to host them is already in place. Utilization will start after the census in 2011</td>
<td>Bangladesh Bureau of Statistics (BBS)</td>
<td>UNFPA</td>
<td>Abdullah Harun Pasha, Deputy Secretary and Project Director</td>
</tr>
<tr>
<td>Strengthening the Department of Population Sciences at the University of Dhaka.</td>
<td>University of Dhaka</td>
<td>1. Academic research, 2. Policy Dialogue, 3. Diploma course for Govt. and NGO officials.</td>
<td>UNFPA Fellowship Award are helping young researchers to produce better master's thesis. Six policy dialogues, 6 round tables and 8 symposia. DPS introduced professional post-graduate degree (MPS). It also offers “Diploma in Population Sciences”, for students from different ministries/divisions/NGOs.</td>
<td>Department of Population Sciences Dhaka University</td>
<td>UNFPA</td>
<td>A.K.M. Nurun Nabi, PhD, Professor and Director</td>
</tr>
</tbody>
</table>
2.3 ASSESSMENT OF THE PROGRAMMATIC STRATEGIES

A few points shall be clarified for the reader prior to elaborating on the issues.

The RRF is of limited use for the evaluation, as elaborated above. In order not to dismiss the efforts and investments by UNFPA unfairly, the ET concentrates much of its discussion in the following chapters on activities and processes. Outputs and outcomes are addressed as far as the RRF limitations allow. In this light, even with non-conclusive RRF objectives and indicators, the ET did not introduce new benchmarks or alike, but aimed at capturing the spirit and meaning of an objective or indicator and commented against what the ET understood as the intention of the RRF. At the same time the ET discussed internally thoroughly and included in the report those assessments which found agreement and consensus among the ET members.

The absence of assumptions or risks in the RRF format leaves it uncertain to which extent UNFPA would assume responsibility for the achievements of the objectives.

Having said so, the evaluation with its strategic weight, discusses the progress towards objectives, issues and examples independent whether UNFPA itself is considered accountable or one of the partners or an issue is subject to other dynamics and developments. The point of this evaluation is less who achieved what, but rather which processes helped and which constraints were encountered and what could this mean for the next CP.

For example, when the reports states that SBAs are performing deliveries without supervision, the “support to the DGFP is not sufficient to strengthen human resource management to minimise vacancies, absenteeism and dissatisfaction among staff; that victims/survivors are provided with shelter and food, but psychosocial care and empowerment for income are included only in some cases, then it means that these situations are not desirable, but not that UNFPA is accountable. However the question is indeed raised whether UNFPA should or should not contribute to incomplete concepts and whether it is UNFPAs role to see such short comings and to aim at overcoming these shortcomings given that UNFPAs funds are used. The first above mentioned example illustrates that there is not one and sole answer to this question, because health system issues can be beyond the scope of UNFPA and are complex. This does not mean to say that issues which present or contribute to constraints should not be mentioned as shortcomings, but rather to identify them and, depending on their nature, consider whether UNFPA has an opportunity or obligation to act or not.

2.3.1 RELEVANCE

2.3.1.1 Reproductive Health Component

In general, the reproductive health component of the 7th CP is based on learning from previous country programmes, the UNDAF framework, MYFF, ICPD agenda, UNFPA strategic plan, MDGs and the PRSP targets. It has also given attention to national priorities based on the health SWAp and HNPSP.

The most focused target population of the 7th CP are the poor, women and adolescent and youth. Bangladesh is the eighth most populous country in the world with a population of 160 million but occupying only 3000th part of the world’s land space. The population growth momentum has volatile effects on the high population density, poor land/man ratio, slow economic growth and massive unemployment and poverty in the country. UNFPA continues to play a crucial role, as an integral part of its mission, in supporting the government through enhanced capacity building, increased supply of FP commodities and improved access to quality FP services in Bangladesh for decades. Bangladesh FP programme has achieved progress in raising the contraceptive prevalence rate (CPR) from less than 40% in 1991 to about 60% in 2008\textsuperscript{13}. The increasing CPR trend has reflected in the decline of the total fertility rate (TFR) since the early 1970s from 6.3 children per women to 3.4 in the early 90s but witnessed a plateau which has lasted for a decade at a TFR of 3.3. However since 2004 TFR has continued to decline to reach 2.7 in 2007\textsuperscript{14}. Further, an increased number of contraceptive users is most essential for reducing maternal and child mortality as well as achieving the HNPSP targets for Net Reproductive Rate and TFR. The same documents show a low contraceptive use rate among teenage couples, an insignificant

\textsuperscript{13} MDG progress report 2009
\textsuperscript{14} BDHS 2007
reduction in unmet need for FP and disparities in using contraceptives among rural/urban couples, mothers with education level and households with wealth and in geographical location. The continuation of UNFPA support with an appropriate strategy and activities in this regard was and is vital to increase CPR and reduction of fertility in the country.

The programme emphasised capacity development, awareness development and increased access and demand for RH information and services with a focus on fertility and maternal mortality and morbidity reduction. UNFPA continued supporting the FP programme of Bangladesh with capacity building and improved access to quality family FP information and services in a similar manner as in previous CPs carrying the activities from one CP to another, which remains a question of relevance of such support.

Bangladesh had a high MMR\textsuperscript{15}, with 320 deaths per 100,000 births before starting the 7th CP. This means there were about 11,000 to 12,000 women dying from pregnancy or childbirth complications every year in Bangladesh. Bangladesh has one of the world’s highest rates of adolescent motherhood, nearly half of the adolescent girls (15-19 years) are married, 57\% of them become mothers before the age of 19, and half these adolescent mothers are acutely malnourished. These high mortality rates are underpinned by the fact that nine out of every 10 deliveries took place at home, mostly assisted by unskilled attendants or relatives. As a response to this crucial problem deliveries by skill birth attendants are considered as an effective strategy to reduce the MMR to 143 by 2015. The new HNPSP proposes a two-pronged strategy to increase skilled birth attendance: 1) to promote institutional services in all upazilas with creation of the cadre of fully-trained midwives as per standard of the International Confederation of Midwives; and 2) sustaining and expanding home-based services, particularly in places with geographic or social restrictions on seeking care from facilities. In the 7\textsuperscript{th} CP, UNFPA focused more on home-based services with support to community based birth attendants (CSBAs) as a temporary approach to fill the gap until sufficient midwives exist. UNFPA is supporting this process which contributes to the MDG goal. As per the strategic direction, UNFPA has been supporting the in-service midwifery training (6 months) for the existing nurse midwives based on developed curriculum. UNFPA support in this regard is pertinent to reduce MMR in the country.

There is no accurate figure available on the ratio of obstetric fistula related morbidity in Bangladesh. According to an estimate in 2003\textsuperscript{16}, 71,000 women with fistula were living in Bangladesh. It means that the rate of women with fistula was 1.69 per 1,000 ever married women. It is understood from the discussion with DGHS senior officials and service providers in Sylhet Medical College that the actual number is likely to be considerably much higher. UNFPA supports to ensure sustained fistula prevention and treatment at the national level as part of the “Campaign to End Fistula”.

Almost 26\% of the population with a growth rate of 3.5\%\textsuperscript{17} in Bangladesh lives in urban areas, a large proportion of the population is slum dwellers. Mortality and morbidity among slum dwelling women are high. Rapid urbanisation has resulted in vast intra-urban differentials in environment and health conditions, with those living in slums having the most acute and chronic hardships. Moreover, these slums are growing in huge numbers and shifting or expanding. According to a survey conducted by Asian Development Bank (ADB) and Planning Commission, GoB (1995-96), 61.30\% of the urban population in Bangladesh falls below the absolute poverty line while 40.20\% falls below the hard-core poverty line. The health knowledge of the urban slum dwellers and their access to RH services are low. UNFPA jointly with ADB, DFID, Swedish International Development Cooperation Agency (SIDA), ORBIS\textsuperscript{18} and GoB financed the Urban Primary Health Care Project (UPHCP) to improve the health status of the urban population, especially the urban poor, through improved access to and utilisation of efficient, effective and sustainable services primary health care services. Major services of the UNFPA supported 30 Comprehensive Reproductive Health Care Centre (CRHCCs) are safe motherhood, SRH information and services for adolescents.

One-third of the population in Bangladesh are the youth and adolescents, who appear to be poorly informed about RH including physical well-being, sexuality and health. Whatever knowledge they have is

\textsuperscript{15} Bangladesh Maternal Mortality Survey, 2001
\textsuperscript{16} Obstetric Fistula Programme in Bangladesh: Situational Analysis, Strategies and Future Programme-2011 to 2015, Directorate of Health, 2010
\textsuperscript{17} www.nationsonline.org/oneworld/Country.../Bangladesh-statistics.htm
\textsuperscript{18} ORBIS (a non-profit humanitarian organisation devoted to blindness prevention and treatment)
incomplete and confusing. The projects have considered skill development training followed by peer education and enter-education approaches to face the challenge of the youth and adolescents. The livelihood training could be useful to draw attention of the population on participating in skill development trainings. This is an appropriate strategy to increase awareness among this segment of the population.

Bangladesh’s thriving sex industry has one of the highest client turnovers in Asia with sex workers averaging 19 clients a week. Condom use among the clients of sex workers is very low. This low condom use, risky behaviour and general lack of understanding about HIV are not limited to clients of sex workers. In fact these traits are widespread and heighten the chances of an HIV epidemic in Bangladesh. The similar situation also exists in case of transgender people. The situation justifies interventions for these high risk groups. At present, only UNFPA provides assistance to brothel based sex workers in the country. On the other hand, GFATM and FHI provide similar assistance to transgender population in the same locations where UNFPA provide support. This duplication of activities has an insignificant scope to add value. Moreover, there was nothing specified in the current RRF of UNFPA to go for interventions among the transgender population.

A UNFPA project supports and supplements the GoB efforts to provide RH services including FP, reproductive tract infection (RTI)/ Sexually Transmitted Infection (STI), HIV/AIDS, safe delivery for poor and distress refugee population in Cox’s Bazaar. This project is also based on the UN mandate to ensure the services for vulnerable and refugees. However, Rohingya refugees outside the two camps in Nayapara and Kutapalong are not covered through this project.

2.3.1.2 Gender Component

Gender is designed as a separate component for the first time in UNFPA Bangladesh in the 7th CP in order to achieve the specific UNDAF outcome, i.e. “societal changes are realised to reduce discriminatory practices and to pursue equity and empowerment for women and girls”. The component started its operation with two outcome indicators: “National mechanisms in place to monitor and reduce gender-based violence and civil society partnerships actively promote gender equity, women’s and girl’s empowerment and reproductive rights”. The single output of the component i.e. “rights of women and girls promoted and gender equity enhanced” exists with three output indicators in the RRF: i) Proportion of community leaders and decision makers sensitised through UNFPA programmes who promote gender issues increased to 20%; ii) reliable data on gender-based violence becomes available; and iii) male coalition established that supports women’s rights and condemns violence against women.

The component attempts to address issues related to gender equality/equity and women’s empowerment through the following activities: dialogue with policy makers including political bodies and media personnel; sensitisation of opinion leaders; creating platform of influential men; providing training to the service providers in Mother and Child Welfare Centre (MCWCs), other service delivery points, law enforcing agencies and community based interventions in partnership with NGOs and CBOs in the two selected zilas; support (medical, legal and shelter ) to victims of violence in the two selected zilas; training on RH and reproductive rights (RR) to disadvantaged women working in garment factories and tea plantations; establishing linkage with the micro credit programmes of NGOs and related programmes of other UN agencies; community mobilisation through several mass communication methods (e.g. community group meetings, folk song, film shows, orientation and training). All of these activities have been designed to bring positive changes in the attitudes and behavioural practices in the population on gender, reproductive rights, reproductive health, violence against women and prevention of HIV/AIDS.

There are six projects in the gender component which are being implemented through partnership with different ministries of GoB, NGOs and civil society groups.

The project “Promotion of Gender Equality and Women's Empowerment” aims to reduce gender based discriminatory practices and empower women and girls at both national and grass root levels. It also focuses on promoting women’s rights and prevention of gender based violence through raising awareness. Within the project period (2006-2010) the major activities comprised training of part time field motivators (PTFM); sensitisation of community people through arranging courtyard and community meetings by the 180 PTFMs; upazila level coordination meetings of PTFM to report and share field experiences; debate competitions at school level, development and RH and rights, workshop with 100
TABLE 7: GENDER COMPONENT PROJECTS & IMPLEMENTING PARTNERS

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<thead>
<tr>
<th>Project</th>
<th>Implementing Partner</th>
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</thead>
<tbody>
<tr>
<td>Promotion of Gender Equality and Women’s Empowerment</td>
<td>Directorate of Women Affairs (DWA), MoWCA</td>
</tr>
<tr>
<td>Advocacy on Reproductive Health and Gender</td>
<td>Dept. of Mass Communication, Ministry of Information</td>
</tr>
<tr>
<td>Involvement of Religious leaders in Human Resource Development</td>
<td>Ministry of Religious Affairs Ministry</td>
</tr>
<tr>
<td>Advocacy on Reproductive Health &amp; Gender Issues through the training</td>
<td>Ministry of Home Affairs</td>
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<td>institutes of the Ministry of Home Affairs</td>
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<tr>
<td>Promotion of Reproductive Health, Reproductive Rights, gender equality</td>
<td>Dept of Labour, Ministry of Labour and Employment</td>
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<tr>
<td>and Prevention of HIV/AIDS in Tea Garden Communities</td>
<td></td>
</tr>
<tr>
<td>Promotion of Reproductive Health, Gender Equality &amp; Women’s Empowerment</td>
<td>BGMEA</td>
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members of Bangladesh; scout; workshops to sensitise people from private sectors on issues related to gender, policy dialogue with policy makers, civil society, media professional and NGOs; support to women victims of violence against women (VAW) through Women Support Centres (WSC) in two zilas; produce training materials and behavioural change and communication (BCC) materials; exposure visit by the project staff; formation of a males engaged network and engaging boys and men to combat GBV including South Asian regional consultations with men and boys in zilas.

The projects are addressing the MDG goals 3 (directly) and goals 4, 5 and 6 (even 2) indirectly. It has been reported by Department of Women Affairs (DWA)\(^{19}\) that the UNFPA funded project is different from other projects as it is involving both women and men in promoting gender equality and in combating violence against women (VAW). The intervention engaged men and boys and formed men’s networks to prevent VAW, which has been identified as a remarkable shift from Women in Development (WID) to Gender and Development (GAD).

The DWA has produced series of useful training manuals and BCC materials related to gender and reproductive rights in collaboration with UNFPA. Women support centres in two zilas are providing shelters to women who become victims of domestic violence.

The activities of the project “Advocacy on Reproductive Health and Gender” concentrated on awareness raising, sensitisation and motivation of people through mass campaigns, orientations, sensitisation workshops for the local journalists, dissemination of messages on VAW, RH, RR and other gender related messages through folk music, documentary, film shows and arranging courtyard meetings for women. In addition to working in Sylhet and Cox's Bazaar the Ministry uses UNFPA resources to celebrate special days, such as the World Population Day in all the zilas in Bangladesh. UNFPA supports the Ministry to have 15 folk singer groups across the country. The equipments such as multi-media, cinema vans, audio visual programmes on dowry, early marriage, RH, gender violence and other gender related issues are used for community sensitisation.

The project “Involvement of Religious leaders in Human Resource Development” was designed to sensitise religious leaders, core leaders, managing committee of the mosques, marriage registrars through training and orientation regarding women’s rights and empowerment. The aim was to make the leaders to change agents for the society. The project activities involve orientations, training, refresher orientations through the Islamic Foundation, the Imam Training Academy and the Hindu & Buddhist Religious Welfare Trust. About 18260 religious leaders (Muslim, Hindu & Buddhist) are brought under the training activities of the Ministry of Religious Affairs with UNFPA support\(^{20}\) (Standard Progress Report, 2009).

The support received from the project is relevant for the ministry especially in context of making their activities visible at local level. The project has already provided training to 18260 people belonging to different religious groups including 2250 Madrassa educated women. According to the project staff/

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19 See also Progress Report, 2009
20 Standard Progress Report, 2009
officer of the ministry, 50% of the trained religious leaders have been active as opinion makers. But this is only assumption\(^2\) (MTR, 2009).

The Islamic Foundation has provided a 45 days training on basic life skill to imams since 1975 throughout the zilas of Bangladesh. The reading materials published by the Islamic Foundation are life skill based of which a book on “family welfare” discusses on the relationship between women and men and rights of property according to Islamic law. A small part on RH and women’s health are also incorporated in the second chapter of the book. Although the concepts of gender or VAW are not included in the regular training curriculum, under the UNFPA intervention the imams are getting a five days long training on gender, RH and HIV/AIDS (making the 45 days training to 50 days). The resource persons are especially hired from the local administrative bodies of the GoB. Although there is a training manual, resource persons give varying lectures depending on their personal experience.

No mechanism has been established to institutionalise the course and materials of the 45 days regular training curriculum. The module of the training curriculum, which was distributed to trainees in the districts, was confined to the lecture sheets only. The ET was told that a inter-religious dialogue on VAW will be held in January, 2011, where four lectures will be given from four religious perspectives.

The activities of the project “Advocacy on Reproductive Health and Gender Issues through the Training Institutes of the Ministry of Home Affairs” include capacity building through trainings of law enforcing agencies on RH, HIV/AIDS and gender related issues. Training of Trainers (TOT) has been imparted to more than 100 trainers. From March 2003 to 2006 MoHA implemented a joint funded (DFID, UNFPA) project (Tk. 81200,000) on promotional activities on gender, RH, RR, and HIV/AIDS. In March 2006 the project has been merged in the new CP. However, the new project limits the scope for continuing some of the activities of the joint programme such as the training centres are no longer funded by the UNFPA project. As a result the regular reporting system from the training centres has been postponed. However, all the training programmes have already been incorporated in the National Training Academy.

The MoHA has integrated RH, RR, HIV/AIDS and gender issues into their regular training courses for the members of law enforcing agencies. Moreover, the project director of the UNFPA funded project will submit a guideline to introduce a separate “Help desk” in all police stations to support women (as per the decision of a recent meeting of the MoHA on 9.10.2010).

Key informants reported that the MoHA had 4,500,000 grass root level Ansar (para police force entrusted with the responsibility to support and assist the police forces in maintaining law and order situation of the country) and village defence police (VDP) officers, they could be involved as catalysts to combat violence against women. Leaders of Ansar-VDP (15 women and 15 men) attended the two workshops (30 women and men in each) organised by MoHA. As Ansar-VDP work at union level, increasing their capacities is likely to provide much more positive results.

The project “Promotion of Reproductive Health, Reproductive Rights, Gender Equality and Prevention of HIV/AIDS in Tea garden Communities”, implemented by Department of Labour in Srimangal of Moulvibazar, include activities such as community group meeting, trainings, orientations, workshops, drama and film shows, cultural events, health care and contraceptive supplies. The project aims to change behaviour of women and men involved in tea plantations. The stakeholders of the project (tea plantation workers, trade union leaders, garden managers) have been acquiring knowledge to improve the situation of RH, RR and STI/HIV/AIDS prevention. The project is also working towards policy provisions and capacity building of the service providers of both, the tea gardens and the Labour Welfare Department.

Through promoting the RH, RR & STI/HIV the tea garden project is contributing to the CP outcome 4, i.e. women and girls are supported and empowered to make decisions about their RH and rights. The ET have been told by key informants that consciousness is growing among the tea garden workers about RH, as well their knowledge about STD and the use of condom has increased and is becoming popular.

KI reported that positions of medical officers are vacant and treatment of sexual and reproductive health (SRH) problems is not available. As a result office documentation as well as field work is disrupted\(^2\) (SPR, 2009). As 62 gardens under the project are scattered up to most remote and hilly area of 3 zilas of

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\(^2\) MTR, 2009

\(^2\) Standard Progress Report, 2009
the Sylhet Division, it is indeed nearly impossible to supervise well the project activities with the present number of supervisory staffs\(^{23}\) (MTR, 2009).

In 2009 the tea workers who received condoms increased by 9% from the previous year\(^{24}\). At present the number of regular condom users is on average 352 tea workers per month. The majority of the workers are now aware how to prevent STI/HIV/AIDS\(^{25}\). They seek information regarding RTI/STI services from the health centres. Besides this, the project also started in 2009 to supply oral pills for contraception. Females are demanding this product highly. During this year 12,428 cycle oral pill were distributed. On average, 1,036 tea workers per month received pills.

The activities of the “Promotion of Reproductive Health, Gender Equality & Women’s Empowerment in the Garment Sector” of the BGMEA include workshops, policy dialogue, trainings, refresher trainings including also owners and mid-level managers. The activities are designed according to the 7th CP outcome 1 ("Population and reproductive health related strategies effectively translated into program especially for the poor and vulnerable") and 3 ("Women and girls supported and empowered to make decisions about their reproductive health and rights"). Sensitisation and awareness of garment workers about the need of healthcare, FP, RH, safe motherhood, prevention of HIV/AIDS, STI and tuberculosis are also imparted in the project activities. The project also includes garment factory owners and mid-level officers like compliance-, welfare-, and administrative officers in the sensitisation activities. The BGMEA is providing healthcare facilities to the garment workers through 11 health centres in Dhaka and Chittagong where workers receive free treatment. It is expected that due to the project interventions changes would occur in the attitudes and practices of garment workers also in respect to reducing fertility and increasing use of contraception, knowledge of health care and hygiene. However, manuals for garment workers are not based on the rights of the female workers as the mandate of International Labour Organisation Convention.

The project involves both workers and owners to run Day Care Centres for children, which are very much useful. However, as the results are only limited according to the annual progress or activity reports, it is difficult to make comments about the qualitative changes brought by the project. The intervention with BGMEA can be used as an example of contributory public-private partnership. Being inspired by the project BGMEA has been working for the improvement of healthcare facilities of garment workers, especially of women, including the establishment of total of 11 health centres within and outside Dhaka, a plan to develop more health centres and two hospitals in Dhaka and Mymensingh for garment workers. The health centres and hospitals run by the BGMEA would be supplementary to the mainstream health centres as well as contributory to provide health support to the garment workers, who are playing important roles to bring remittance for Bangladesh.

In summary it can be stated that the gender component is in alignment with Bangladesh’s National Priority 5: “Gender Equity and Advancement of Women”. The component addresses the MDG 3, CP, ICPD and a national priority. However, activities are inconsistent with output and outcome indicators. Output indicator 1 refers to the sensitisation of community leaders and decision makers without addressing women and girls as well as the larger community who need to be made aware. Reliable data for the indicator 2 on gender based violence were not available at the project management. Indicator 3 is not specific to the outcome.

### 2.3.1.3 Population and Development Component

Bangladesh has a number of important policies, like the National Population Policy, the National Health Policy, and the National Policy for Advancement of Women, all approved by the appropriate authorities. Many on these policies are on paper and are not implemented in real sense because of low awareness among the general population. To implement these policies, support from the key groups like the parliamentarians was/is required to create a public opinion on various issues including the harmful practices (like early marriage, dowry, gender-based violence), and seek their support for proper implementation of the policies. The parliamentarians however require adequate and authentic information to make their deliberations, and it was appropriate to have a project with the parliamentarians and provide them with the information through various policy briefs, workshops etc.

\(^{23}\) MTR, 2009
\(^{24}\) Source: FWs Contraceptive reports. SPR, 2009
\(^{25}\) Source: FWs Contraceptive reports. SPR, 2009
The parliamentarians along the national level planners and policy makers need evidence based information in a user friendly manner so that they can contribute to policy formulations. To generate this information requires research activities, training of relevant staff, and producing policy briefs on those issues. The project with the Planning Commission aims to cater this need. Research activities in various forms have to take place and findings from those addressed in policy formulation and activity planning. Also, mid-level officers must be trained on RH, reproductive rights and P&D issues, and get the ability to analyse data disaggregated by sex, age, economic status and location. The project with the National Institute of Population Research and Training (NIPORT) meets this end. All these three projects (with the parliamentarians, Planning Commission and NIPORT) supported by UNFPA to reach the output-6 are therefore appropriate and relevant.

The national and sectoral plans and policies need to have linkages between population gender concern issues, development and poverty reduction strategies. For this purpose data need to be disaggregated by sex, age, income level. Good demographic outcomes depend on good policies which are again based on quality data. BBS, as a national statistical organisation is obligated to provide timely and appropriate data for planning and monitoring of national development goals. It is therefore relevant to have a project with BBS in order to strengthen the organisation with useful tools like the digitized Geographic Information System maps and develop the capacity of the staff for interpreting the census data and developmental indicators. However, to effectively use these data and formulate effective population policies and strategies and address discriminatory provisions towards women and girls need trained human resources. The UNFPA project with the Department of Population Sciences (DPS) addresses the issue of HR development. Considering these factors, it can be stated that both projects (with the BBS, and the DPS of Dhaka University) are contributing to output-7 are therefore relevant.

2.3.2 Effectiveness

2.3.2.1 Reproductive Health Component

UNFPA provided support to both, the supply and the demand side for increased access as well as demand for RH services, which would result in increased use of contraceptives and deliveries with SBAs including CSBA.26 UNFPA’s support for the FP Directorate is based on typical strategies like capacity building through trainings for staff, development of strategies (Adolescent Sexual and Reproductive Health (ARH) and communication), development of communication materials for the demand generation and as an aid for field level staff, supply of equipment and commodities.

UNFPA has provided concentrated support to two low performing zilas through contributing to major positive changes in the reproductive life in the pilot area as well as at national level. In general, the support for trainings and the supply of equipment and commodities are essential integral parts in strengthening the supply side of the FP Directorate. The technical trainings like on emergency obstetric care (EoC), anaesthesiology, clinical contraception and theatre management have refreshed the services providers in MCWCs and Union Health and Family Welfare Centres (UHFWC) with updated knowledge. This enabled them to provide improved quality services at MCWCs and it has contributed to the increasing numbers of client flow. The ET observed in UHFWCs that they were not well prepared for deliveries and clinical contraception, autoclaving of equipment was irregular, inactive standard waste disposal system and client flow management poor with limited confidentiality and counselling. It is fair to assume that the ET did not visit particularly poor performing facilities and therefore it is also fair to assume that the observations indicate that the trainings had little impact in the UHFWC in improving service quality. Surely, this has aggravated further due to staff absenteeism and poor retention. Human resources management, as a resource management system, goes of course beyond the scope of UNFPA and the projects. However, the point shall be made, that investments and interventions should be designed, planned, managed and reported upon within the respective context and its facilitating and constraining factors and linkages established and/or described.

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26 Based on available information; No MCWC data were available, neither mentioned in the project reports, baseline and endline survey reports.
The major problem for quality service provision lies with the supply side which is facing lack of manpower, absenteeism, lack of equipment and supplies (particularly in UHFWCs). UNFPA is yet to influence on developing planning and accordingly allocate resource at local level to be more effective in programme implementation. Low supervision as compared to MoH own standard, monitoring and on-site technical assistance remain problematic in making the facilities fully functional.

The cervical and breast cancer detection is now well incorporated within the Bangabandhu Sheikh Mujib Medical University in Dhaka. The orientation on cervical and breast cancer screening for service providers at zila to union level service providers has contributed to an increased number of referrals and treatment cases.

The flip chart on FP, RH, safe motherhood, HIV/AIDS and gender is useful for Family Welfare Assistants (FWAs) as a ready reference for use in counselling couples. The ET observed and understood from the discussion with participants that the trainings on client segmentation and satisfied clients for FWAs and community people were conducted on the same day. The trainings were mostly lecture based with one exercise which seems to be exhaustive and difficult to retain the knowledge.

UNFPA supported the development of the National Communication Strategy for FP and RH in 2008. This strategy addresses the needs and concerns of adolescents, young people, and women and men of reproductive age for their FP and RH related education, information, counselling and services. The major activities at local level to increase demand are community meetings, campaigns for FP and safe motherhood, street drama, interpersonal communication with FWAs and promotion of family planning week. The national level communication activities include short film, TV spots, radio jingles, and celebration of world AIDS day and award for media people. However, the utilisation of the strategy is limited as no action plan has been yet developed by the DGFP.

The ET understood from the meetings and group discussions in the zilas that people better recall messages which they received through interpersonal communication with “field” staff and reinforced through media like radio and TV. The villagers hardly can recall community activities like meetings and street dramas as a source of relevant messages. The community meetings and street dramas were organised at Upazial and Union level and generally attended by local elites and not reaching mass people residing in villages. No assessment data of effectiveness of the different sources of information is available in the end line survey. A separate study on the effectiveness of the various communication means could provide an objective assessment.

Development of more effective communication with poor, teenage couples and couples in hard to reach pockets and communities and people with unmet needs or who are reluctant to use any FP methods is still now a challenge for the FP Directorate. According the DHS 2007 report, 45.6% of the teenage girls (15-19) are married and 57% of them become mother before age 19. An effort was made to orient FWAs on more effectively generating demand particularly among newly-weds to delay pregnancy by using contraceptives. Health consequences for mother and children have a higher risk for teenage mothers than a newly-wed of older age, which was not properly communicated to teenage couples to reduce maternal and child morbidity and mortality.

The skilled birth attendant training makes many FWAs and HAs enthusiastic about their changing role in their communities because of their higher income and social status. Many of them are performing normal deliveries and referring complicated cases to appropriate facilities in time. They also counsel pregnant women, their husbands and in laws on importance of deliveries by CSBAs. This effort has resulted in increased number deliveries by skilled birth attendants which included CSBAs and other skilled birth attendants of the GoB, NGOs and private facilities. The baseline and end-line survey shows an increase in number of attended deliveries from 17% to 42% in Cox’s Bazaar and 24% to 57.9% in Sylhet. This achievement is much higher than the target for output-1. The regular communication activities also contributed in raising at least 1 ANC visit during last pregnancy which has increased from 59% to 80% in Cox’s Bazaar and 53% to 81% in Sylhet. Other projects operated by different agencies and private sector might have multiple effects on the increased birth attended by skill person. However, the SBAs intervention also has some limitations. The routine job of FWAs and health assistants, such as domiciliary

27 Wahiduzzaman Chowdhury, Strengthening Family Planning Program in Maternal and Neonatal Health Initiative in Four Zilas of Bangladesh, UNFPA, 2001
visits for awareness raising and commodity distribution, is hampered due to the added responsibilities. Due to lack of supervision at “field” level quality of the delivery service by the SBA could not be ensured.

Most of the performance indicators show a much higher increase in Sylhet compared to Cox’s Bazaar. Besides UNFPA supported interventions other NGO implemented RH projects such as by Access, Ma-Moni and Projonmmo may have contributed to this high performance in Sylhet. The voucher scheme has contributed in increasing institution based deliveries in Cox’s Bazaar. It is stated that the institution based delivery in Ramu upazila has increased from 275 in 2007 to 982 in 2010 (up to November) 28, whereby UNFPA also supported the voucher scheme in the Ramu upazila. Group discussions with community members confirm that the voucher scheme has had an effect on increasing facility based deliveries in Ramu upazila in Cox’s Bazaar. Although the voucher scheme is designed for poor women only, many non poor also benefitted because the selection criteria were not strictly followed and/or the systems misused.

UNFPA has been assisting the Directorate of Health in providing quality obstetric fistula treatment in Bangladesh by establishing a fistula centre in the Dhaka Medical College and a rehabilitation centre for poor clients. The service was expanded to 10 medical colleges of Bangladesh due to the high demand, and creates hereby better access for clients. A national level advocacy meeting was effective to raise awareness among policy makers, donors and other stakeholders about the importance for obstetric fistula care. As a result of advocacy29, the Islamic Development Bank funded the establishment of a centre of excellence on obstetric fistula in Dhaka. Moreover, it is being incorporated in the next health SWAp of Bangladesh. A total of 2,387 patients successfully were treated so far. However, a number of patients either rejected or the operation were not successful. The mass population in the country is not aware about availability of the fistula care services as no media campaign and promotion is done. Limited community awareness activities led to inadequate knowledge of people on prevention and treatment. Even the RH service providers in facilities and SBAs were not oriented on fistula prevention and the promotion of the services. The existing referral link with service delivery points from community level to the fistula treatment centres is not yet adequate. Unavailability of continuous and full time trained doctors in the service centres is one of the major obstacles to ensure the services in the centres. Moreover, regular turn-over of trained doctors remain a long lasting problem, as in the Sylhet Medical College. A Recovery, Training and Rehabilitation Centre has been established with collaboration of an NGO. The centre provides counselling to patients and their family members and provides livelihood training with matching grants and links up with micro credit agencies. The poor patients are satisfied with the support offered through the treatment and the centre as it helps them to rehabilitate in their family as well as community30. A total of 271 poor women have received the livelihood training and 50 of them are now working as community advocates. They are active in raising awareness on fistula prevention and referring clients to the treatment centres. The ET understood from meetings with service providers and patients that counselling of husbands and patients are perceived as not fully effective because a number of patients receive the same treatment repeatedly because they did not adhere to the advices they had been given. The counselling for the failure cases appear ineffective due to lack of appropriate counselling for a longer period of time.

In the urban health project, the comprehensive capacity building approach for staffing with short and long term trainings in-country and abroad, supply of equipments and commodities and on- site technical assistance have ensured access to quality SRH services including safe delivery including EoC, STI and clinical contraception. The support in the development of appropriate BCC materials and service promotion has resulted in high demand for the CRHCC services. Adolescent friendly corners in the CRHCCs along with field level education through peer educators have drawn the attention of adolescents to get information and services from the CRHCCs. Significant increase in adolescent health care which indicates that the youth corners in the CRHCCs and that it can be replicated in all service centre. As stated by the project office, it had been decided by the project that at least 30% of each service should go to poor free of services charges (included services, laboratory tests, medicine and accommodation), This system has allowed urban poor women easy access to and demand for RH services. A unique system of criteria to identify poor was developed through

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28 DSF Monthly and Yearly Summary Data, Ramu Upazila Health Complex
29 Mid Term Review Report on UNFPA 7th Country Programme for Bangladesh, 2009
30 Mid Term Review Report on UNFPA 7th Country Programme for Bangladesh, 2009
The poor are given Red TBA to perform normal deliveries. The ET observed that there are areas for service facilities. It was noticed that there were some signboards on “Adolescent Friendly Hospitals”, particularly in the upazila health complex and also reported that no referral link was established to R. The interviewed adolescents were not well informed about adolescent friendly RH service facilities. It was also to be noticed that the awareness level is comparatively low among the rural adolescents and youth compared to their urban counterpart, possibly due to their low exposure to multi-source information.

This gained knowledge enabled the youth also to organise campaigns and efforts to prevent early marriage and dowry in their community. Sensitisation sessions were organised also for parents and communities in order to extend necessary RH related support to the adolescents and young people. These sanitisation sessions were rather few and it does not appear that they could adequately promote a congenial atmosphere for the adolescent and young people to share RH related issues and problem with their parents.

The interviewed adolescents were not well informed about adolescent friendly RH service facilities. It was also reported that no referral link was established to RH service facilities. The ET observed that there were some signboards on “Adolescent Friendly Hospitals”, particularly in the upazila health complex and MCWC but the ET did not find appropriately arranged counselling and services facilities to address the special needs of the youth and adolescent.

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**Table 8: Performance in CRHCCs**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2006 Poor</th>
<th>2006 Total</th>
<th>2010 (up to November) Poor</th>
<th>2010 (up to November) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>26532</td>
<td>102313</td>
<td>56818</td>
<td>183284</td>
</tr>
<tr>
<td>Deliveries</td>
<td>4443</td>
<td>18882</td>
<td>12833</td>
<td>41398</td>
</tr>
<tr>
<td>PNC</td>
<td>6490</td>
<td>28217</td>
<td>13779</td>
<td>44447</td>
</tr>
<tr>
<td>RTI/STI</td>
<td>3737</td>
<td>16246</td>
<td>7847</td>
<td>25312</td>
</tr>
<tr>
<td>Family planning</td>
<td>72165</td>
<td>72165</td>
<td>115040</td>
<td>115040</td>
</tr>
<tr>
<td>Adolescent HealthCare</td>
<td>43678</td>
<td>43678</td>
<td>32809</td>
<td>105837</td>
</tr>
<tr>
<td>Others</td>
<td>90985</td>
<td>265156</td>
<td>155715</td>
<td>502304</td>
</tr>
<tr>
<td>Total</td>
<td>248030</td>
<td>546657</td>
<td>394841</td>
<td>1017622</td>
</tr>
</tbody>
</table>

| %                  | 45%       | 39%        |

Awareness and demand for RH have increased among the refugees in Cox’s Bazaar. It has provided CTBA to perform normal deliveries. It seems to be effective in increasing deliveries by skilled birth attendants. The project provided for 5,171 services during the last 11 months of 2010 which includes 778 deliveries, 3014 contraceptive users, 1,207 STI treatment including partners.

Awareness development, provision of services and empowerment of the young people to protect them especially from STI and HIV/AIDS in Cox’s Bazaar and Sylhet zilas are main concerns of UNFPA. In addition, round table meetings and publications in daily newspapers and workshops had sensitised policy makers and service providers at the national level. The master trainers of schools and local officials of the MoYS provided training to the peer educators who in turn conducted trainings for their school mates and club members. Meetings with community leaders and guardians were also organised to sensitise and create an enabling environment. The ET understood from the discussions with school students and club members that their knowledge on transmission and prevention methods of HIV/AIDS has increased due to project’s interventions which is confirmed by the End line surveys as tabled below:

The discussion with young people in the pilot areas revealed that their knowledge on FP and consequences of dowry and early marriage is reasonably good while they have seem to have a better grasp on 4 (HIV/AIDS, early marriage, dowry and FP) out of the 16 discussed training topics. All topics had been addressed in a day-long lecture based training, which was too exhaustive for them to remember all. However, the participants who were exposed to diversified sources of information like the peer education, media, text book and enter-education could reinforce their learning. They were more inclined to share their knowledge with their classmates and friends. However, the girls, as compared to boys, were found more conversant on the issues. It was also to be noticed that the awareness level is comparatively low among the rural adolescents and youth compared to their urban counterpart, possibly due to their low exposure to multi-source information.

This gained knowledge enabled the youth also to organise campaigns and efforts to prevent early marriage and dowry in their community.

Sensitisation sessions were organised also for parents and communities in order to extend necessary RH related support to the adolescents and young people. These sanitisation sessions were rather few and it does not appear that they could adequately promote a congenial atmosphere for the adolescent and young people to share RH related issues and problem with their parents.

The interviewed adolescents were not well informed about adolescent friendly RH service facilities. It was also reported that no referral link was established to RH service facilities. The ET observed that there were some signboards on “Adolescent Friendly Hospitals”, particularly in the upazila health complex and MCWC but the ET did not find appropriately arranged counselling and services facilities to address the special needs of the youth and adolescent.

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### Table 9: Knowledge of Youths and Adolescents on RH Issues

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline Survey</th>
<th>Endline Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cox’s Bazaar</td>
<td>Sylhet</td>
</tr>
<tr>
<td>Know at least one way of prevention of HIV/AIDS</td>
<td>71.2</td>
<td>76.9</td>
</tr>
<tr>
<td>Know about STI</td>
<td>16.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Know about family planning methods</td>
<td>58.8</td>
<td>54.6</td>
</tr>
<tr>
<td>Know source of contraceptives</td>
<td>90.1</td>
<td>90.3</td>
</tr>
<tr>
<td>Intention for FP method use</td>
<td>56.8</td>
<td>57.6</td>
</tr>
<tr>
<td>Ever experienced in intercourse</td>
<td>9.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Use of condom in the last intercourse</td>
<td>31.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Service delivery points offer information and services for young people</td>
<td>6.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Sex workers using contraception during last intercourse</td>
<td>n.a</td>
<td>n.a</td>
</tr>
</tbody>
</table>

**Note:** All figures are in percentage.

The endline survey is the source of these data. Some data (knowledge about STI) may be questionable since there seems to be an inconsistency—while all other indicators show (major) improvements (including use of condom) but the knowledge of STIs has declined.

The intervention for sex workers in two brothels aimed at raising awareness on safe sex, creating an enable environment and reducing violence in Tangail and Mymensingh. The major strategies of the interventions are the use of self help groups, male watch dog groups, VWA committee and advocacy. All these seem to be effective in raising awareness, creating enabling environment and promote safe sex and reducing VAW. The awareness level on HV/AIDS and STI has increased with continuous effort by the self help groups and peer educators. It is also reported in different studies that condom use among the sex workers has increased as well as the sale of condoms in and around the brothel shops. It is also reported in the study on Tangail brothel that 98% of the sex workers know about transmission and prevention of HIV/ AIDS, 79% about STDs and 97% believe that condom can prevent them from HIV/AIDS and STI. Similarly, awareness about HIV/AIDS and human rights issues as well as condom use has increased among transgender persons in two sites of Dhaka city and 50,000 condoms were distributed each year. A Partnership Forum on HIV and Sex Work Issues was established at the national level in 2009 to provide strategic guidance and framework on HIV and sex activities, share experiences, guide to formulate and to accelerate an appropriate advocacy agenda with active participation of sex workers in HIV prevention. However, any active role of the forum is yet to be observed.

#### 2.3.2.2 Gender Component

The Gender Component seems to be effective only in context of its project approach to create awareness through imparting training, distributing equipments, producing BCC materials or raising awareness of target population.

However, there is a lack of coordination between the projects and across the components. Also within UNFPA activities gender is not dealt with as a cross cutting issue, and he Gender Component works rather in isolation. Both the RH and the P&D components implement gender related activities without having any coordination with each other or the gender component. One of the major challenges of

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33 The baseline survey conducted in August 2006 covered 10,605 households including 6,400 in rural and 4,215 in urban areas in Cox’s Bazaar and Sylhet districts. The endline survey conducted in December 2011 and covered 12,381 households from Cox’s Bazaar and Sylhet districts (7,428 rural and 4,953 urban) with confidence level of 95% and the response rate was around 98%.

34 Operation Research on Brothel Based Sex Workers and Self-Help groups for Prevention of STI and HIV/AIDS, 2009

35 Sadhana Rout, etl., Review of Existing and Emerging Patterns of Sex Work in Bangladesh in the Context of HIV and AIDS, 2008
having an independent gender component is that gender issues might not be looked at by the other components assuming that the gender component would take care of it.

Most of the activities included in the gender component have already existed in other components, especially in the RH component. It appeared that almost the entire advocacy related activities on gender, RH, RR and HIV/AIDS were pulled together to form a new component on gender as recommended in 6th CP. However, although the gender component was designed to achieve the MDG 3, i.e. “promote gender equity and empower women”, indicators of empowerment has not been included in the component and rather several projects have been designed without a consolidated action plan. At present different ministries and line departments/directorates of the GoB are the implementing partners of different projects of UNFPA, including the gender component36. The absence of a gender action plan and a coordinated programme strategy create barriers also for collecting consolidated data from different projects.

The logical framework/RRF has limitations as the indicators are broad and there is only 1 indicator for the target population in gender, i.e. 20% achievement is required. Considerable changes as e.g. average age of girls at marriage increased above 18 years; BDHS, SVRS include gender desegregated data analysis etc. are mentioned in the 7th CP planning and tracking tool, have been observed through available data, however, there is no mechanism to know the direct impact, i.e. 20% achievement of UNFPA. Although the programme has a well structured monitoring mechanism with specific tools (7th CP planning and tracking tool, updated 2010 and 7th CPAP, 2006-2010), none of the projects have used it. The core group proposed for the “Promotion of Gender Equality and Women’s Empowerment Project”, consisting of Upazila Women Officers and another officer from the local administration, were supposed to be responsible for monitoring and updating the data base. However, in reality the core group was all along inactive. The absence of data base/MIS, proper monitoring, lack of coordination amongst the different projects, absence of an impact assessment/study (except a Knowledge Attitude Practice study on the activities of MoRA) and lack of coordination limit the scope of identifying significant effects of any of the projects of the gender component.

The effect of the innovative approach, e.g. part time field motivators, could only be observed or be understood through the evaluation discussions with different stakeholders. The Women in Development (WID) focal points/Women Affairs officers at zila level are virtually inactive due to inadequate support and resources. They are not even considered as Gender And Development (GAD) focal points. UNFPA is playing a role through funding different activities, however, the success or limitation of a project is dependent on other factors which are related to constraints such as lack of resources, facilities and management capacities.

The Women Support Centre has been perceived as a reliable response to the growing needs related to domestic violence37. However, it is evident that the Women Support Centres (WSC)38, implemented by the DWAs, are not identical in their operations in the two zilas. The centres are supposed to provide shelter, legal-, psychological- and life skill support to the survivor women. The women are also allowed to bring their kids below five years of age with them, who are supposed to get early childhood education. There is also a trade instructor to provide life skill training to the women of WSC. However, it has been observed that although there were women (9 in Sylhet, 13 in Cox’s Bazaar) living in the WSC, they are having limited life skill training, insufficient to make them self reliant or economically independent. The trade training in Sylhet has almost disappeared as the inmates were not interested because they did not see that they would get benefit out of it. No linkage has been established to market the women’s products or to provide skill training to women based on the market demand of the products. There was no counsellor in the Sylhet WSC to provide psychological support to the survivors. Although the staff informed that they provide psychological support, none of them had received training on counselling related to gender or VAW (even though one has been working in the centre for the last 14 years in Sylhet). The WSC support is limited to women victims only of domestic violence, not to other kinds of violence. The legal procedure is also slow in pace.

36 In the RRF partners of the gender component are different than those of project implementing partners.
37 Nasreen, 2008, BNWLA, 2005
38 The MDG- Spain (UN-GoB Joint Programme on VAW) project has planned to construct WSC in seven more zilas.
Women’s cultural and economic dependency on their husbands become much stronger than the life skill training provided to them. As the support provided by WSC, are insufficient for their self-reliant most women have no option than going back or negotiate with their husbands or in-laws. The cases against husbands are mostly negotiated outside court because the women remain a “weak” party in the cases. This indicates that WSC activities are mainly confined to temporary shelter to women and almost do not make any difference to their economic or social empowerment.

Of all the activities, the different governmental (DWA, MoI) and non-governmental actors appreciated the role played by the part time field motivators (PTFM) in creating awareness of women groups and men and community members at grass root/union levels. About 185 PTFMs are working at the grass root level, 80% of them are women. As gender discrimination and VAW are more frequent in rural areas, the presence of PTFMs is expected to have a positive effect, even if the project has a single impact which would be improving the knowledge and networking capacities of the PTFM on several gender related issues. The PTFMs work beyond their TOR and bring or inform the women survivors about the Women Support Centres. The DWA in the two zilas also get news on violence from very remote corners through PTFMs (field interviews and observation).

It has been observed that the District Information Office (DIO under MoI) is closer linked to the DWA than to other departments. There seems to be a tension between the DIO and the District Family Planning office since the celebration of the World Population Day by DIO (Sylhet). The close linkage between DIO and DWA is useful, especially for raising awareness through dissemination of information on preventing GBV. The tension between DIO and Family Planning (FP) office is giving a reverse picture in Sylhet as FP activities are usually done by FP Directorate. There must have been a lack of proper understanding between the two departments. The dissemination of FP related activities by both DIO and FP is relevant and this must be well communicated to the relevant departments by both government and development partners

Interviewed journalists thought that the training was useful but feel Government agencies lack collaboration and often do not go beyond their mandates. For example, nothing is done on trafficking by the MoI. Similarly drug abuse is also a crucial problem, but remains untouched. Dowry, VAW and religious fundamentalism are different from one upazila to the other (Group Interview, Sylhet).

So far about 40,000 religious leaders have been trained through the activities implemented by MoRA, but no group has emerged with views as a change agent for gender equity. Imams reported that the Masjid

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39 The WSC at Sylhet was a project of the government of Bangladesh from 1995 to 2001 (Dhaka and other divisional cities). From 2001 to 2007 the project was supported with the revenue budget of the GoB and from 2007 (September) to June 2009 (with an extension until December 2011) UNFPA provided all the support except the salaries of the staffs. Since July 2009 UNFPA is providing the house rent, salary of the legal advisor, local transports, equipments etc. Although there is a One Stop Crises Centre at Sylhet Medical College Hospital, no official or unofficial linkage to the WSC has been established (in Cox’s Bazar the OCC has recently been in operation admitting a woman on 20 December, 2010). The Social Welfare officer (male) is in charge of the WSC at Sylhet as the Assistant Director. Vital posts are vacant including the position of a medical officer and a matron, As opposed to the Government managed WSC at Sylhet, the WSC at Cox’s Bazar is managed by the NGO Mukti and implemented by DWA. The ET was informed that the managerial capacity has not been built for Mukti. They have capacity constraints for the day to day management. The project extension was managed in a manner that it appeared to be a threat for the employees as they feel insecure and fear losing their job and some have already left the WSC. There is no counsellor or psychologist at any WSC. However, the referral linkage of Mukti is stronger than in Sylhet for the rehabilitation of women survivors. In December 2010 Mukti rehabilitated five women survivors against violence: one to IPSA, one to a tailoring shop, 2 to the garment industry and one is now a health worker in the malaria control programme. This linkage is possible for Mukti as it runs 17 other projects as an independent NGO. The ET was told that the project manager of Mukti is the member of the VAW committee of the Cox’s Bazaar Medical College Hospital and its “Women Friendly Corner” (a project supported by UNICEF). However, the Onestop Crises Centre (OCC) of Cox’s Bazaar just started its official operation with which Mukti or DWA has yet to be linked.

Monitoring of the WSC by DWA is almost invisible and there is no database to get information on VAW (as mentioned in the output indicators that “reliable data on gender-based violence becomes available”)

40 Data show that in Cox’s Bazaar 135 cases of VAW out of 233 cases of WSC has been negotiated outside the court and only 7 has been resolved within court (Progress Report, October 2008-November 2010, WSC, Mukti, Cox’s Bazaar).
committee is not sensitised about violence against women and discourage the Imams in this regard\textsuperscript{41} (MTR, 2009). The project is the first ever effort to provide a five days orientation training for Imams on gender and HIV/AIDS in the Imam Training Academy. However, the quality of the training seems unattractive. The book or reading materials are not given out, except of a few handouts. The only visual presentation was on HIV/AIDS, which was appreciated by the participants.

As per the TOR between UNFPA and Partner the Imam Training Academy must hire resource persons from outside to provide lectures on gender issues. However, the Director of the Academy may deliver one lecture out of 24 classes. The instructors (there are four regular instructors in the Academy) reported that they often face problems in getting Resource persons’ time and feel that they could have been deliver the lectures if they had received TOT. The staffs of the Academy do not know whether the resource persons have got an orientation on gender and other issues included in the course outline.

There are 400,000 Imams and Muazzins (caller for prayer), 20,000 Hindu and 4000 Buddhist religious leaders in the country of which a small number are brought under the purview of the project. The MoRA has proposed to include at least 40,000 religious leaders to be trained under the 7th CP, and at least 40,000 religious leaders to be trained through the zila offices of the Islamic Foundation, as well as Hindu welfare trust and Buddhist welfare trust offices\textsuperscript{42} (SPR, 2009).

The project implemented by MoLE is not in line with the aim of the gender component as it is mainly promoting knowledge on RH, RR, HIV/AIDS, STI of tea garden workers in Sreemangal. Although the awareness about RH, RR, HIV/AIDS, knowledge about STD and use of condom are increasing among the tea garden workers, it is limited to the awareness raising and use of safety methods. No attempt has been made to mainstream the activities.

The project implemented by BGMEA received training from UNFPA on M&E, orientation on English and computer use, on gender, HIV/AIDS, RH, FP and nutrition. BGMEA is dependent on UNFPA’s technical support which is useful for the “image building” of BGMEA to buyers. However, in future, BGMEA would like to have the following added in the project as part of an expansion: rights based approach: GBV, occupational health and a better equipped clinic (e.g. having an ultrasound machine). As per the 7th CP proposal, the BGMEA planned to establish a linkage to micro-credit, but no such linkage is active so far. Moreover, manuals for garment workers are not based on the rights of the female workers as stated in the International Labour Organisation Convention.

The BCC materials of different components often lack relevance and receptivity of the project participants. It is evident that training manuals and materials have been developed in such a manner that all the participants are educated enough to understand the language, which does not meet the needs of who are unable to read. Of all the materials only the TOT materials of peer educators and the BGMEA training materials seem attractive with colourful pictures, however, the pictures are often gender stereotyped (e.g. pictures showing a women feeding children or holding in laps while men sitting beside). The dramas in audio-visual production are often hard to understand by mass people. There is also evidence of producing negative material which is observed in DWA office (a replica of ‘Banchte Shekha’ poster, submitted to MoWCA). This indicates that BCC materials and training manuals need to be produced in a participatory manner injecting much thought into it. The training sessions observed by the ET are mostly one way lecture based; without giving any scope of participation to the audience.

2.3.2.3 Population and Development component

In terms of the project related to output-6, the project on involvement of the Parliamentarians in RH, rights, gender issues and development started only two years ago after the newly elected government took office from the care taker government and adequate activity did not take place to comment on effectiveness. However, the few steps taken so far to initiate policy dialogues with the Parliamentarians have received very good responses. Like in other countries, the Parliamentarians in Bangladesh are extremely busy people and their participation at workshops and policy briefs is less and are dependent on continued reminder from the project personnel.

\textsuperscript{41} Mid Term Review Report on UNFPA 7th Country Programme for Bangladesh, 2009

\textsuperscript{42} Standard; Progress Report – 2009
The project with the Planning Commission on integration of population and gender into national and sectoral planning is basically a process oriented project with the intent to capacitate the planners and policy makers from various Ministries with updated information and knowledge. Although the project fully achieved its training/orientation plan, the courses are however designed without having a thorough needs assessment, and putting in place a mechanism to follow-up the trainees.

The project with NIPORT on support for policy planning and programme research for population development did take up research on gender based violence, RH needs assessment for garments workers, youth and adolescents, maternal health and morbidity, etc and have disseminated findings from those researches to the policy planners. But as there is no follow-up mechanism, these are not documented and it cannot be known whether the findings are addressed in national and sectoral plans.

In relation to output-7, major work related to capacity building of the BBS staff on data collection, and digitalisation of the map is completed. The system is therefore all set to work. In 2011 a census will take place in Bangladesh and the available database will be utilised in the newly installed geographic information system for analysis and use (particularly for RH related data). On the other hand, the project with the Department of Population Sciences of Dhaka University is producing skilled human resources in the field of Population through regular Masters and Diploma courses. Through their faculty and graduate research it is enriching knowledge bank in the field of population, RH and gender. The department is working as resource centre by assisting other agencies (both government and NGOs) to build their capacity for population planning and programming.

![Picture 6: Women Support Centre]
2.3.3 Efficiency

Financial efficiency

A budget versus expenditure statement was provided by the UNFPA office. The expenditures statement (see table) depicts with few exception a high level of utilisation for the funds, both Direct Execution (Dex) and National Execution (Nex), between 80 and 99%.

The project managed by the parliament was on hold for around two years which can well explain the underutilisation (66.25%).

Further elaborations, in particular the differences, (even though minor) between the RH and gender components as well as the lower level in the P&D component would require more analysed data which the ET did not receive.

The high utilisation of funds indicates solely that the funds were largely effectively used, i.e. the funds were spent, it does not yet allow a conclusion on the efficiency in the utilisation of these funds. The ET attempted to present some basic financial analyses, however did not receive further data and information from the UNFPA office. This was reasoned with the UN finance system which routinely closing down between mid December and mid January and no data would be accessible. The table shows an example of a basic possible overview and categories which would allow some indications of financial efficiency.

### Table 10: Budget versus Expenditure Statement

<table>
<thead>
<tr>
<th>Component</th>
<th>Project &amp; IA</th>
<th>Budget (USD)</th>
<th>% Expend.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH</td>
<td>DGHS (NEX)</td>
<td>7 122 627</td>
<td>90.99</td>
</tr>
<tr>
<td></td>
<td>DGFP-MCH (NEX)</td>
<td>2 847 908</td>
<td>99.96</td>
</tr>
<tr>
<td></td>
<td>LGD (NEX)</td>
<td>2 140 199</td>
<td>95.31</td>
</tr>
<tr>
<td></td>
<td>RTM (NEX)</td>
<td>479 600</td>
<td>98.27</td>
</tr>
<tr>
<td></td>
<td>BRAC (NEX)</td>
<td>28 000</td>
<td>99.79</td>
</tr>
<tr>
<td></td>
<td>UNFPA (DEX-DGHS, DGFP &amp; LGD)</td>
<td>6 942 998</td>
<td>87.95</td>
</tr>
<tr>
<td></td>
<td>DYS (NEX)</td>
<td>571 358</td>
<td>88.11</td>
</tr>
<tr>
<td></td>
<td>DHDSE (NEX)</td>
<td>560 725</td>
<td>95.17</td>
</tr>
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<td></td>
<td>UNFPA (DEX-DYS &amp; DHDSE)</td>
<td>543 930</td>
<td>79.62</td>
</tr>
<tr>
<td></td>
<td>DGFP-IEEM (NEX)</td>
<td>760 323</td>
<td>93.38</td>
</tr>
<tr>
<td></td>
<td>UNFPA (DRE)</td>
<td>783 686</td>
<td>87.88</td>
</tr>
<tr>
<td>Gender</td>
<td>MOGCA (NEX &amp; DEX)</td>
<td>1 496 541.00</td>
<td>92.25</td>
</tr>
<tr>
<td></td>
<td>MOHA NEX</td>
<td>271 630.00</td>
<td>86.76</td>
</tr>
<tr>
<td></td>
<td>MOI NEX</td>
<td>543 624.00</td>
<td>97.36</td>
</tr>
<tr>
<td></td>
<td>BGD$G104 (MOHA &amp; MOI) DEX</td>
<td>407 542.00</td>
<td>84.73</td>
</tr>
<tr>
<td></td>
<td>MORA NEX</td>
<td>1 169 900.00</td>
<td>98.18</td>
</tr>
<tr>
<td></td>
<td>Tea garden NEX</td>
<td>666 931.00</td>
<td>95.83</td>
</tr>
<tr>
<td></td>
<td>BGD$G102 (MORA, MOLE &amp; BGMEA) DEX</td>
<td>316 142.00</td>
<td>88.68</td>
</tr>
<tr>
<td>P&amp;D</td>
<td>Project/NEX &amp; DEX</td>
<td>1 832 566.0</td>
<td>73.36</td>
</tr>
<tr>
<td></td>
<td>NIPORT &amp; BBS</td>
<td>67 543.00</td>
<td>80.41</td>
</tr>
<tr>
<td></td>
<td>Planning C</td>
<td>88 000.00</td>
<td>86.46</td>
</tr>
<tr>
<td></td>
<td>Dhaka Univ</td>
<td>273 707.09</td>
<td>66.25</td>
</tr>
</tbody>
</table>

The above statement shows a high level of utilisation, both Direct Execution (Dex) and National Execution (Nex), between 80 and 99%. However, the ET did not receive further data and information from the UNFPA office which was reasoned with the UN finance system which is closed down between mid December and mid January.

### Table 11: Possible Overview of 7th CP Project Budget and Expenses, 2006-2010, per cost category

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Proposed project budget 2006 - 10</th>
<th>Project expenses</th>
<th>% budget per cost category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commodities/medical material</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent costs</td>
<td></td>
<td></td>
<td></td>
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In the context of the 7th CP with emphasis on the two zilas of Sylhet and Cox’s Bazaar, at the same time nationwide interventions, it would also have been of interest to compare the budget allocated to and expended by or for these two zilas versus the remaining 64 zilas. In absence of such data no statement can be made on additional costs as compared to the changes seen in the zilas.

Similarly, the debate about Nex and Dex could benefit from a more detailed ex-post analyses.
Efficient use of resources other than funds (human resources, equipment, physical assets, time)

To maintain its programme in Bangladesh, UNFPA has a Representative, a Deputy Representative and eight national staff (including 2 ARs and an OM), along with 12 programme staff, including professionals in areas such as, HIV/AIDS, Reproductive Health, Midwifery, Humanitarian Response, M&E, Gender, Communications. The CO also has 9 National Project Professional Personnel (NPPPs) placed with the Government who play an important facilitating role. UNFPA has two field offices in Cox’s Bazaar and Sylhet to undertake special pilot initiatives and other regular activities in the field and to maintain liaison with GoB and NGO counterparts at zila level.

An evidenced assessment of the utilisation of resources other than funds would require adequate time and data for a detailed assessment. During the multiple interviews the ET conducted and documents reviewed it appears beneficial to make a few distinctions:

- Within UNFPA all programme staff indicated to spend around 60 – 80% of their working time for technical work, the remaining time for administrative and financial tasks. This would appear to be a reasonable rate and an efficient use of technical personnel. However in further elaborations “management” of the projects was still listed as the main, and time consuming part of work. Since these statements cannot show to which degree each individual programme or operation staff would use well her or his time, the statements appear to be contradictory and would require more detailed diagnosis and work analyses. At the same time it is striking that (almost) none of the interviewed staff would list readings, updating technical knowledge and elaborating of medium or long term strategies as part of their work, while it has to be acknowledged that it might appear natural that people do not list them specifically, because many would categorise them (updating technical knowledge, readings, elaborating strategies) as broader "technical work".

- In the partner offices the main remark made by several key informants addressed the utilisation of NPPPs. These positions are expected to support technically and strategically their respective offices. Reportedly much of their time is spent to respond to frequent requests for administrative, organisational and other non-technical tasks. It seems they are seen and treated rather as inbuilt parts of “their” offices than additional technical and strategic assistance. Some very long term continuation of the same NPPP position for many years underlines that the actual purpose of a NPPP has faded away over the years and the NPPPs do not appear to be well used. A thorough revision of their tasks and their TOR are imperative.

- Besides the remark that in the UNFPA office a number of not functioning desktops and chairs are stored in the office (in the “consultant room”), which might indicate an “over-efficient” use of assets, no striking observation on the use of physical assets and equipment was made during the short visits to the various, UNFPA supported, offices. A thorough assessment and review of procurements list could not be made within the timeframe of the evaluation.

- A number of key informants raised concerns about the extraordinarily long time periods the office required for processes in procurement and recruitment of staff. See further under the chapter on management systems.
2.3.4 IMPACT

2.3.4.1 Reproductive Health Component

The following has to be understood under the light that it is not possible to show an absolute impact of the UNFPA programme because other players are also contributing. Moreover, many interventions are nationwide and even two districts are not exclusively and entirely covered by UNFPA.

The percentages mentioned in the RRF indicators were mostly of national status and in some cases targets mentioned as per the national strategy due to absence of baseline data from the pilot districts. The population and maternal health programme of the country is supported by multiple donors besides the Government’s own programme and UNFPA’s support. The private sector like clinics, private practitioners also contributed in this regard. All these factors might have impacted on CPR, which is 60 percent including 10 percent for traditional methods. This is 10 percent low compared to the target of 70 percent as per indicators for outcome 1. The intervention also could not achieve the CP targets (increase 15% compared to baseline) for both the pilot zilas. As per baseline and end-line surveys CPR increased by 49%

61.9% in Cox’s Bazaar and by 45.5% to 53.9% in Sylhet.

GRAPH 1: BASE-END-LINE RESULTS: KNOWLEDGE ON CONTRACEPTIVES IN COX’S BAZAAR

Continued awareness creating activities have contributed to well aware people about importance of small family and use of contraceptives in Bangladesh. As per the endline survey, 38% people are buying contraceptives (nonclinical) methods in two districts. However, impact is noticeably low in case of teenage couple, poor, and people living in hard reach pockets.

However, the discontinuation rate for FP methods has remarkably decreased from 59% to 32.9% in Cox’s Bazaar and 58% to 30.1% in Sylhet.

GRAPH 2: BASE-END-LINE RESULTS: KNOWLEDGE ON CONTRACEPTIVES IN COX’S BAZAAR

GRAPH 3: BASE-END-LINE RESULTS: PLACE OF DELIVERY IN COX’S BAZAAR

The strategy of utilising SBAs and a voucher scheme had an impact on outcome level with increased number of births attendant by skilled health person in Cox’s Bazaar and Sylhet. However, it has little effect on impact level which is reflected in the recent evaluation of the SBA programme by UNFPA as well as in Bangladesh MDG progress report 2009. It is stated in the evaluation report that SBAs can perform

43 The ET received conflicting information. As stated above, the revised RRF was explained as not yet in use and not final and therefore the ET considers inappropriate to refer to the RRF.
44 The RRF mentioned a target for CPR of 70% (according to the RH strategy paper) and not specific targets for zilas. The baseline survey found the CPR in the pilot zilas to be around 45% and during a workshop with stakeholders, the target was reset at 55%. This was also reflected in the revised RRF.
45 Source:ICPD/15: Bangladesh’ Experiences Progress and Challenges, UNFPA, 2009; Discussion with different levels of key informants like government and NGO officials at upazial and district level.
11.3% deliveries and limited to boost the deliveries to 50%. The MMR was 348 (SVRS 2008), which is lagging behind the MDG target 143. Since the obstetric fistula treatment is comparatively new in the country and no morbidity and mortality data on related to fistula is available in the country, it is difficult to make any comment on the impact of the intervention.

The Urban Primary Health Care Project has contributed to the reduction of maternal and child mortality and morbidity and contraceptive use in urban areas. The project performance statistics indicated that it has already provided 9% higher number of the targeted poor during 2010.

The project for the Rohingya refugees in Cox’s Bazaar was covering a small population, so the scope for measuring impact is limited. However, the number of contraceptive users and the delivery by skilled providers increased and the number of STI cases decreased. It was recorded that the Contraceptive Acceptance Rate from 28% to 70% and deliveries by skilled birth attendants from almost nil to 87%.

The concentrated services for the camps are the main reason for this high impact. High awareness and knowledge has impacted on personal hygiene and intention for taking preventive measures for HIV/AIDS and healthy life among the target population. The baseline and endline survey data reveal that a good number of the youth have intention to use family planning method in future. There is also an increasing trend reported for condom use in the last intercourse by the youths. However, it is very difficult to know from the surveys about comprehensive knowledge on HIV/AIDS (who know two methods of preventing HIV infection, reject two misconceptions and understand that a healthy looking person can have HIV), which was an indicator for outcome-2. According to MICS 2009, only 14.6% youth have a correct knowledge of HIV prevention and it is found lowest in the Sylhet division with 9.4%. It is reported that 79% bonded and 75% independent sex workers used condom during the last sex activity and consistent use of condom was 40% and 25% among the bonded and independent sex workers of Tangail brothel. 44% of the sex workers in Tangail go to a medical doctor while other 36% go the local pharmacy for STI treatment. With the assistance by CARE for more than one and half decade, the self-help group of Tangail becomes effective in raising awareness and creating enabling environment in Tangail. However, the scenario might be different in Mymensingh, but the study only covered Tangail.

2.3.4.2 Gender Component

Quantitative or qualitative impacts cannot be shown due to the absence of monitoring tools or any impact assessment study. The baseline or endline surveys do not include project activities of gender. It is, therefore, not possible to comment on the extent of sensitisation or changes taken place in people’s attitudes.

However, the ET’s experience in the zilas and progress reports indicate that knowledge and networking capacities on several gender related issues are improving. For example, the DWA in two zilas get news on violence against women from very remote corners through the part time field motivators, the MoI is

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46 Operation Research on Brothel Based Sex Workers and Self-Help groups for Prevention of STI and HIV/AIDS, 2009
having access to modern equipment for the first time. Folk singers are officially involved in promoting government activities. Linkage has been established with the DWA at zila level, the MoRAis providing training to different religious groups including 5 day long refresher trainings to the Imams on the Training Academy.

The gender component works through different implementing partners/ministries to raise awareness among different segments of the population. However, gender related issues, especially VAW fall more in the purviews of the MoWCA and thus the gender component is engaged in more activities with the DWA than others, especially on women’s empowerment. The indicators of empowerment (social, economic and political), however, have not been given due attention and the activities are limited to raise awareness. Working through the DWA, which itself is “less empowered in the context of resources and capacities”, as observed in the field and evident through the statements of officials in both the central and field levels, limits to show visible impact of the component. Building the capacity of the DWA and/or steps to sustain the activities of field motivators have been listed by the DWA staff as useful steps to show the effectiveness of the intervention. It must be mentioned here that the MoWCA has been termed as the “weakest Ministry” by ministerial KI as far as its resources are concerned. It has to cover 64% of the population including women and children with only 0.8% of the total budget. The DWA faces problems in implementing the project activities as there is no Women Affair Officer in 68 upazilas. One officer has to cover two to three upazilas, which hampers both the quality and quantity of activities. In Sylhet 6 upazila officers have to work in 12 upazilas. Maintaining accountability and monitoring have become difficult under such a circumstance47.

2.3.4.3 Population and Development Component

In relation to output-6, the project with the parliamentarians is still not matured enough to comment on whether the project has adequately assisted government in developing the population policy. However, the few steps taken so far to initiate policy dialogues with the parliamentarians have received very good responses. In the recent past there has been an informed discussion in the parliament and in the Parliamentary Standing Committee on issues related to health and population programme, and actions taking on certain issues. This indicates that there is potential from this project to contribute in policy making and future programming.

The project with the Planning Commission trained, oriented and informed large number of mid-level government staff on result based management and gender, and had dialogue on issues like climate change, community support, programme integration, reduction of TFR, aging population, urbanisation, etc. These trainings are expected to create impact on the participants and contribute positively to population and gender planning. However, as a follow-up mechanism is not in place, it is difficult to determine whether the trainees have adequately contributed to integrating P&G into national and sectoral planning, nor could it be said whether the GoB is assisted in developing an action plan for the population policy. All the activities like the research, dissemination and staff training that NIPORT conducted may have lead to inclusion of population and RH concerns into national and sectoral development plans. But it is difficult to firmly comment on this because of lack of follow-up information.

In relation to the output-7, the project with the BBS is at the stage of take off. BBS has installed the geographic information system, and they are ready to collect and use information on RH during the 2011 census and utilise the information of the geographic information system for analysis and help monitor progress towards the realisation of national development goals, action plans and progress towards MDG and poverty reduction in the country. The project with the Department of Population Sciences of Dhaka University has filled some knowledge gap, and the need for skilled personnel in population, RH and gender. However, as a follow-up mechanism is not in place it is difficult to determine whether the human resources produced by the department have contributed to formulating action plans for the population policy, or created policies against harmful practices. However, senior faculty members of the department participated as members of the national population council and contributed in population policy making.

47 However, it has been reported by DWA that recently 700 staffs have been recruited under revenue budget and they would be placed in the vacant posts of different Upazila.
2.3.5 **Sustainability**

While sustainability has to be reviewed from its various aspects, i.e. financial, technical, programmatic as well as institutional sustainability, the ET preferred initially for easier reading a consistency in the structure of this chapter, aligned with the previous chapters. In order to respond positively to a request received from a commenter on the draft report, this chapter was restructured according to the main elements of sustainability. The ET maintains however that consistency would be more reader and user friendly.

In overall no or insufficient exit strategies were developed and applied in the CP. UNFPA could (should) have, in agreement with, and jointly designed with the GoB, designed and implemented exit strategies for each project or clearly determined the time frame for each project and the future of their interventions beyond the projects’ life time.

The formulation process of the projects could not be entirely reconstructed by the ET. As far as conveyed by KIs, the ET understands that some participatory steps took place, but KIs commented that during the implementation period decision making was largely in the hands of UNFPA.

Sustainability cannot be well evidenced in absence of a monitoring system and tools which could measure and inform on advocacy, awareness, change in behaviour or empowerment. Therefore the following is based rather on extrapolation and triangulation than on hard data, especially in the gender component.

**Political sustainability**

Political commitment is verbally expressed on high political level. Also, Bangladesh is co-signatory to the respective international treaties. Major challenges which developed at times to barriers for the translation of this commitment into legal, strategic, programmatic and budgetary realities, derived (especially in respect to gender equality) from opposing groupings in the society and from the overall GoB budget limitations.

**Institutional sustainability**

UNFPA having been engaged directly in service delivery and implementation, a dependency on UNFPA had been inevitably created, for the benefit to get the RH and gender agenda introduced and moved forward. Over the years, while the public sector assumed increasingly responsibility and some capacity, the character of UNFPA’s interventions have changed from being the actual actor to working with/through the public sector, however in a proactive and almost pushing role. This could have changed gradually to institutional support and coaching as part of an explicit exit strategy.

Much of the interventions were directed to transfer of knowledge and assistance in service delivery and interventions, but hardly to any management- and/or (delivery-) systems building, which naturally has a smaller sustained effect.

As stated above, some support was directed to policy design and the development of guidelines and training manuals. Provided that such tools and documents are indeed used, such investments lead obviously to a high likelihood of sustainability.

The high attrition rate of government managerial officials, but also trained personnel of public sector facilities, to other departments, other ministries and/or the private sector impair built awareness, expressed commitment and flow in dialogues. Inevitably, it requires planning for continuous high levelled political advocacy, frequent repetitions and permanent investments in knowledge transfers.

The main caveat in the gender component is the absence of a UNFPA Bangladesh gender strategy, neither does gender appear as a cross cutting component within UNFPA. In consequence there is no strategy for systematic mainstreaming, for gender empowerment or for institutional capacity building beyond trainings of individual officers. The lack of a UNFPA strategy cannot be seen as separate from the debate of sustainability in the gender component, since such a strategy is a precondition to design effective, but also sustainable interventions. Also, presently the components in UNFPA work in isolation to each other including the gender agenda, while addressing some of the gender issues.
The interventions of the 7th CP are based on a project approach and not on a programme. Consequently the interventions are constrained in systematically building up the institutional capacity of the MoH&FW, MoWCA or of the other respective ministries in their gender agenda.

In relation to the P&D component, the capacity building process of the BBS staff on data collection and installation of the digitised geographic information system (up to mouza level) is completed. A server to host the information is already put in place. BBS is in the position to maintain the system in the future with their own expertise and resources. On the other hand, the developing of a workforce with expertise on population policy and programme is a continuous process. Capacity building was largely limited on knowledge transfer to parliamentarians. Awareness rising was also the point of attention in this component. The institutional capacity of the parliament depends on the scope of awareness of the parliamentarians which is naturally less possible to be influenced by the parliament as a state institution.

Programmatic and technical sustainability:

In building up service delivery and implementation systems, another exit strategy could have been applied in the understanding that a successful exit strategy has to start at the very beginning of a project or programme. It means the sequence of direct training, training of trainers, coaching and supervision could have been strategically followed while maintaining a proactive engagement and commitment.

The design and the implementation of some projects created additional dependencies, since funds were also used e.g. for salaries of managerial staff, whereby these elements were not sustainable from the onset of the funding period. At the same time, sense of ownership is obviously a cornerstone for sustainability and for resuming responsibility and leading projects from strategic view. Experiences have shown that projects prescribed and predefined by external bodies are less likely to be fully taken on board and owned by the “recipients”.

The CP invested substantially in various trainings, orientations, awareness creation and similar knowledge transmitting interventions. It can be assumed that knowledge developed in the MoHFW and other ministries will sustain while acknowledging the effects of the high turnover of staff, as stated above. A high number of positions from local to national levels are vacant and replacement by new staff will require training to be effectively functional.

Some additional specific comments for the RH demand side:

- The demand for contraceptive methods will sustain, however is dependent on the “demand side financing” (in this context it means, that the user is paid, not paying). This risk factor is however external to UNFPA, although included in the National Health Policy and the SWAp financing.
- Also, Bangladesh is at present moving from a least developed to a middle income country because of higher levels of income, education, and overall development. In general, education rates are increasing rapidly and people are looking for better well-being in their life. It can be expected that people will be proactively demanding to keep their family size small and seek for better quality services on their own.
- The awareness level about FP, safe delivery and other RH related issues has been increasing but further effective communication will be required to take it to a sustained level which also leads to change of behaviour.
- The knowledge gain through the various projects will be retained by the different target groups to varying degree dependent on effectiveness, quality and completeness of the intervention. For example, the interventions engaging participants among the youth of the life skill and livelihood education are not sustainable without donor support. These may sustain if the life skill and livelihood education are incorporated within regular school text book and training curricula of the MoYS. However, the text books and training curricula will not be effectively used unless teachers and trainers are well trained on the topics and skilled in communicating with youths comfortably.

For the RH supply side:

- The CSBAs will be able to continue conducting safe deliveries in their community and refer complicated cases in time. The current technical capacity level of the IEM Unit is effective in designing and developing communication materials on regular issues. However, this technical
capacity is not wide enough to deal with newly emerging challenges like for teenage couples, poor, and people living in hard to reach pockets. Also, the unit’s own budget is not sufficient to develop communication materials. Thus, further external technical and financial assistance will be required.

- The fistula services are already incorporated into public medical colleges and it is being duly considered in the next SWAp. However, since the fistula services are incomplete, lacking adequate counselling of patients and their families and appropriate rehabilitation in their families and societies, additional external technical support will be required.

For the gender component:

- While the available information cannot clearly indicate, whether or to which degree UNFPA’s input led to behaviour change, it is fair to assume that UNFPA has surely contributed. Hereby programmatic sustainability can be considered high, if the current awareness raising efforts are carried forward emphasising actual change in attitude and behaviour.

- It is argued that interventions carried out by the existing system, such as governmental health facilities and personnel, to deliver services and/or carry out interventions, would usually be considered to have a relatively high institutional sustainability. The ET can agree to this general assumption under the condition that decision making is indeed in the hands of the national partners, the interventions are accompanied by systems development; institutional capacity building and required budget allocation are at least planned for. This would require shifting of the strategic focus of UNFPA before it can be concluded that the interventions have indeed a high probability of being sustained.

- Limited attempts have been taken to mainstream the project contributions/best practices within the system. This is highly relevant for sustainability because it would show concrete steps to incorporate the gender agenda into the various sectors’ agendas. For example, with the completion of the project the part time field motivators will also come to an end. One of the activities of the DWA, i.e. the establishment of Women Support Centres (in 7 more districts), has been integrated in the joint UN-GoB (MDG-Spain, 2010-2012) project. Among other activities, the folk songs, films, dramas implemented through the MoI and curriculum of all 14 training institutes to impart specialised training to members of law enforcing agencies implemented by MoHA will be existing after the project’s time, because the curriculum has been integrated in regular trainings. Moreover, in a recent meeting (9.11.2010) of the agencies under MoHA the PD of the UNFPA project was requested to submit a guideline to introduce a separate “Help desk” in all police stations to support women.

- Interventions for important target groups like out-of school youth face similar challenges in being sustained. However the logic is the same as above - the sector Ministries need to allocate a budget to carry the gender agenda (as well as the RH agenda for that matter) for which UNFPA continues to have its advocacy role, while it can spend seed money and funds to test or commence new and innovative interventions with the required accompanying mechanisms.

For the P&D component:

- Continuous efforts in knowledge transfer would be required to move agendas forward. The project with the parliamentarians will need donor support; particularly technical advice for some more time. After the initial period, the responsibility of the project can be gradually transferred to a research wing of MoHFW. Meanwhile, UNFPA can join hand with UNDP to provide support to the Ministry of Parliamentarian Affairs in order to assist the GoB in a more efficient way for more synergy and impact.

- In regards to the project with the Planning Commission, it is expected that the trainees who acquired knowledge from the research, training and policy dialogues will be able to sustain the knowledge and contribute to integrate issues on population and gender into national and sectoral plans.

- The Dhaka University clearly expresses ownership of the UNFPA support through the respective department which is part of the university system.
Financial sustainability

Reproductive Health receives high attention in the National Health Policy and the SWAp pool. The interventions of the UNFPA’s RH component are aligned with the GoB. Hereby, in overall, financial sustainability is as far ensured as the SWAp pool can be warranted, although UNFPA’s contribution to the SWAp pool is rather small.

This implies naturally that the interventions outside the health SWAp pool are financially dependent on the UNFPA. However this fact should be seen in the same light as the reliance of the health sector on the health SWAp pool itself. This includes also issues like the built infrastructure of clinics as the CRHCC with developed capacity enables the Local Government to continue operating the health system in the urban areas. Outreach - and skill development activities will require external financial support within or outside the SWAp pool arrangements for their continuation in future as it is unlikely that the GoB budget allocation for health will be able to cater for all capital costs in the foreseeable future. Also, CTBAs will retain the skill on performing safe normal deliveries and refer complicated cases. However, the camp based RH services will not sustain without donor support. Similarly the interventions of sex workers and transgender persons will require external financial and technical support for continuation.

The MoWCA is an under-resourced ministry. The other related ministries rely financially on UNFPA in addressing the gender agenda in their respective sectors and have not yet an institutionalised budget allocation to assume their respective role in addressing the gender agenda. The interventions in the gender component are therefore highly dependent on external sources as UNFPA.

Financial sustainability appears less of a debated issue in the P&D component. As NIPORT is a government supported institution, the programme will continue even without UNFPA support. However, financial and technical support makes it more effective. Major costs of the BB department’s programme cost is shared by the Dhaka University by providing space, faculty etc. There is scope for the department to sell training using adjunct faculty members and earn more for better sustainability of the programme.
2.3.6 MANAGEMENT SYSTEM

Management systems shall be looked at from various angels:

**UNFPA internally, as far as the systems effect performance**

The current management systems follow, as far as the ET could observe, the general UN and UNFPA guidelines. An assessment of the degree in the actual applications of these systems would be beyond the TOR of this evaluation.

The ET made some observations on the side way without going into details. Only those observations shall be pointed here which seem to be impacting on the performance of the 7th CP:

While the organogram of the UNFPA office (see figure and full sized in annex 6) is in line with UNFPA standards, it does not appear to reflect the needs of the 7th CP in programmes as well as in operations, considering UNFPA Bangladesh is a relatively small office.

- The 7th CP defines three components and it seems that the organogram aimed at structuring the office around the components, however incompletely. The standard organogram is obliging the merge of two components under the same department. This could function well, but requires a good match between TOR/job description and the hierarchical set up.
- Multiple hierarchical layers tend to slow unnecessarily decision making processes in a relatively lean office (a number of key informants raised concerns about prolonged and delayed approval and procurement processes).
- The UNFPA office is too small to allow smooth functioning with maintained departmental/territorial mindsets and it is too large to have an entirely horizontal structure. In any case teamwork relies on fluent, collegial communication, team-spirit and a common vision.
- Positions are vacant for longer periods and some recruitments take up to nine months or more.
- Operations polices are not well known and not comprehensively available in the office (which for example threatened the participation from zilas at the validation workshop).
- The NPPPs are part of UNFPA and represent UNFPA in their respective ministries. Nevertheless they feel not being taken as part of the UNFPA, neither are they full time civil servants, which has put them into a frustrating position. See also below.

UNFPA Bangladesh applies the UNFPA system for auditing its operations. In Bangladesh, all UNFPA-supported projects (NEX) are audited, every year, by the Foreign Aided Projects Audit Division (FAPAD) of the General Auditor's Office. For the last three years, UNFPA has received only unqualified audit reports. Corporately, UNFPA is being audited for its DEX part by the UN Board of Auditors on an annual basis, reporting to the General Assembly of the UN. For their work country offices are selected randomly and it was in 2005 that UNFPA Bangladesh was visited the last time. UNFPA offices are audited by UNFPA's Division of Oversight Services (DOS) and they follow their own schedule. The last audit was undertaken in 2007.
Management systems, as far as common observations could be made on multiple projects

The ERD of the Ministry of Finance is the central coordinating agency for UNFPA programme in Bangladesh. The Joint Secretary of ERD and the UNFPA Representative usually co-chair key meetings, in order to facilitate UNFPA programme in the country and for matter of harmonisation. UNFPA has established partnerships with civil society, GoB and the private sector in the fields of RH, gender and P&D. All UNFPA projects and activities are implemented at national and zila levels and jointly monitored from time to time by ERD, UNFPA, component managers, IPs through field visits, annual component and programme review meetings, studies, qualitative and quantitative indicators. Other UN agencies, DPs and civil society organisations also participate in the review meetings. UNFPA works with key ministries and departments/directorates under the ministries as IPs to implement the programme components.

All the projects are headed by a PD of Deputy Secretary or Joint Secretary (MOI, PC, MORA) level, except the DPS, which is headed by a full Professor of Dhaka University. The PDs perform their regular activities and at the same time look after the project activities. In BBS for example they had to get more than 60 staff on deputation to set up the geographic information system unit. They also received a consultant to support them in these activities.

The PDs are in most cases are assisted by a NPPP and administrative staff from the UNFPA. The NPPPs provide technical and sometime logistics/protocol support to the PD while their colleagues look after the project accounts. The NPPP works closely with the PD, and their offices are in the same campus. The NPPP and a NPA/NFA are recruited by UNFPA and are project staff. As they are UNFPA project staff they are supervised by UNFPA’s chain of command, but are controlled by the PD. Although some PDs are satisfied with the set-up, some are not that happy as they do not get their support when needed because they are called upon by UNFPA for some other assignments/meetings/trainings without the PD being adequately informed. Few NPPPs are not technically appropriate to the project and do not know about government systems. In few cases the NPPP is assigned for two projects, and s/he cannot provide adequate time and support to both the projects. In some project offices, there is inadequate space for the NPPP, and PD suggested that NPPP move to a separate building adjoining their office.

It apparently looked as the NPPPs are loaded with more administrative work rather than technical tasks. The ET has discussed this issue with the NPPP, and found that it is to some extend correct, but they are convinced that it is the only way to keep their demand high with the ministry where they are stationed and reach the technical target for which they are placed there by UNFPA. Some of the NPPPs are not so happy with their position. They consider themselves as the frontlines on UNFPA through whom the visibility of the organisation is flying high or low. However, they do not receive adequate support from the organisation particularly in acquiring logistics and equipment for the project budgeted under UNFPA office. They also stated about disproportionate staff benefits for being a project staff rather being in the “main-stream”.

The ET talked separately with both the NPPPs and the PDs about the possible effect if all the NPPPs are put under one Project Implementation Unit (PIU) within UNFPA, while they could seek complimentary support from each other. The NPPPs and the PDs are of the opinion that the project activities would be more delayed. They would prefer that the current system continues, with some improvements to increase effectiveness. The PDs would prefer to have more control and supervision authority over the NPPPs, and even take responsibility to set salary structure of the project staff, and recruit and fire them stated one PD.

**Management system strengthening as part of UNFPA’s mandate**

The 7th CP did not include systematic development of management systems in the ministries or NGOs, testing those, coaching in the usage and implementation. Therefore it is fair to say that institutional capacity building was quite limited because developing and/or strengthening management and service delivery systems are major elements of institutional capacity building.
2.3.7 Comments on Joint Programmes

The TOR of the evaluation stated that the 7th CP evaluation does not include the joint programmes. This was reiterated during the initial meeting with UNFPA, clarifying that observations only on the side way, if at all, are expected. At the same time the original objective of the inclusion of these programmes in the TOR was to explore the linkage between these joint programmes and the Country Programme. As stated above, a high number of UNFPA staff was on leave during the evaluation process. The ET took those documents into account which were made available while the evaluation was ongoing. The ET found it speculative to comment on the mentioned linkages without going into depth of the joint programmes.

Demand based RH commodity project

This project, funded by CIDA, was recently, in November 2010, concluded. The ET was informed that an end term evaluation was not carried out yet. Therefore the ET refrains from commenting except mentioning that some key informants described this project as a doubtful success in moving the agenda forward, although 15 M $ were spent on procurement of RH commodities and glossy policy briefs and public relation material was produced. The ET initially recommended that a evaluation should be conducted in the near future with a view of capturing the experiences for further use in similar possible interventions since the subject of the project addressed a high priority issue in Bangladesh. This was retrospectively rectified in the comments on the draft report, stating that a “FE done and its findings and recommendations were disseminated in September 2010 and future policy implications (incl. incorporation of the lessons learned into the new health and population sector programme) were discussed in the same forum which was well attended by different stakeholders including high-level MOH officials”. This implies that learned lessons were captured and should show the linkages to the CP. As far as the ET could establish a number of issues show that the projects and the CP addressed complementary issues. In how far the different processes (CP and programmes) managed well to feed to each others think tank, could not be well understood by the ET, because only few references were made to this project in documents and during interviews. A few points though can be made:

- Among the different interventions and trials the project showed that successful progress in health facility based activities depends on systematic improvements of all elements of health (management) systems, especially human resources. This is of course not a surprise and the role a holistic approach is generally well recognised. It underlines the advantages of UN joint programmes when various mandates and expertise maximise mutually.
- The supply side needs to be prepared when the demand side is promoted for increased utilisation of services. The linkages to the CP and even more so to HNPSP have to be made in good time to avoid possible counterproductive effects if the supply is lagging behind the demand. Therefore the role of UNFPA in fora of the HNPSP and SWAp pool is strategically essential.
- Programmatic several lessons can be used for the 7th and for the 8th CP and eventually for policy debates like the formation of a “Voucher Coordination Committees” which support substantially at district and upazila levels the voucher programme for poor pregnant women. The DBRHCP maternal voucher scheme result indicates encouraging note for the utilisation of public health facilities, which may further be rolled out on wider scale.
- Client specific BCC activities and material and even more so, interpersonal communication through peer promoters, community support groups, home visitors and alike, demonstrate a noticeable higher effect, which is in line with the observations made in the CP.
- In this light, the lessons learned of the project confirm the assumption generally made, that strengthening health service facilities increase utilisation of services. In turn it underlines the need of a holistic approach, whereby the experiences of the contributing role of well trained and supported lower level cadres is shared with the CP RH component. Hereby one of the major issues of this project was to train the field workers and field supervisors on register, management information systems as a tool to tackle the RH situation early. The CP can also make use of this pilot project as it tested several service delivery strategies and showed improvements through some basic changes in service delivery mechanisms and proper task based training.
- Public – private partnerships are a further linkage to the CP which can be made in using the experiences in the cooperation with NGOs, which contribute effectively in improving quantity
and quality RH services, particularly the FP methods utilisation. Experiences gained partnerships of communities and local government could be further replicated in strengthening community clinic operations and make the clinic affordable to the community meaningfully through an effective public-private partnership approach.

Accelerating the reduction of maternal and neonatal mortality and morbidity

The project with a life time from 2007 – 2012 is funded jointly by the EU and DFID with a total estimated cost of the project for five years of US$ 31,258,650.00 and was planned to be carried out jointly by UNFPA, UNICEF and WHO. A recently conducted joint EU/DFID review conveys a positive message and provides recommendations for the next year of implementation.

The nature of the project contains options for further linking programmatically and for policy debates due to its relevant innovations for the supply as well as the demand side, such as:

- subcontracting of staff by the public sector,
- performance based incentives,
- quality assurance frameworks,
- emergency obstetric care training and
- quality monitoring,
- zila case investment analyses,
- community support systems as fora to give communities a voice.

Hereby the programme can act as a catalyst provided the mechanisms are established and actually used to extrapolate from these pilots. This is even more essential since the new initiatives would not be sustained if their funding is not ensured after the project period.

However, several key informants identified two main reasons for the extensive delay of around 1.5 years at the onset of the project: apparently an exhaustive struggle between UN agencies for taking the lead of the project and secondly it seems a strategic error was made when during the initial stages key stakeholders and governmental authorities were not or not sufficiently involved in the project design and related decision making which subsequently seems to have led to some blockages. Although this reaction by stakeholders is likely to have been foreseeable at the first place, the lessons should be learned. Key informants however expressed concerns that the same error would be currently repeated as the project is preparing itself for an extension to other zilas and not or not fully involving Government offices.

Reduction of violence against women:

The UN Joint Programme to Address Violence Against Women (proposed start/end dates: January 2010 - December 2012) is designed in line with UNDAF outcome(s): Societal changes are aimed to reduce discriminatory practices and to pursue equity and empowerment for women and girls (MDG3). The budget of the total estimated programme is $ 7,997,378. The following are the outcomes:

1. Policies and legal framework aimed at preventing violence against women (VAW) and protecting and supporting survivors adopted, implemented and monitored.
2. Social attitudes and behavioural changes effected to reduce VAW and discriminatory practices.

The strategy adopted by this programme uses a three-pronged approach: policy, behaviour, and protection.

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48 Accelerate Progress towards Maternal and Neonatal Mortality and Morbidity Reduction, Joint MoHFW Initiative, Draft 1, Joint EC/DFID Annual Review 2010; November 2010

49 This paragraph was commented on the draft report as “.....not necessary for the reasons mentioned above, especially when the validity of the information here (only based on the ‘talk’ with several people) is highly questionable, and indeed the last sentence is not true” However the ET sees 1) significant lessons to be learned precisely in making the linkages to the CP, 2) that interviews cannot just be ignored if the message conveyed might be unpleasant, especially if such messages were conveyed by KI who played significant roles, 3) the messages were conveyed by than one KI or organisation and 3) that KI interviews are essential and generally excepted working tools in reviewing exercises and should not be dismissed as “talk with several people”:
First, the joint programme will address the issues related to policies and implementation of the adopted laws and conventions. Activities aimed at adopting and implementing policies preventing VAW and protecting victims/survivors will include (i) enhancing the capacities of GoB, (ii) improving information related to gender and gender discrimination, and (iii) promoting active advocacy and monitoring by Civil Society.

Second, the joint programme will address the attitudes and behaviour of men and women, boys and girls themselves. Activities toward strengthening intergenerational societal and behaviour changes in order to reduce VAW will include awareness raising, networking and developing capacities of gatekeepers and stakeholders.

Third, the joint programme will provide survivors of VAW with immediate relief and rehabilitation. Immediate protection of vulnerable individuals and victims of VAW will be provided through a comprehensive package including the expansion of the successful Bangladesh “UN shelter”.

These interventions are built on well grounded successes gained by the different agencies. Some innovative activities have emerged from opportunities created by the different ongoing interventions or by the changes occurring in Bangladesh. Activities allow the scope of effective ongoing interventions to be increased either by widening the number of beneficiaries, or by deepening the impact and increasing sustainability. The programme has three specific outcomes directly contributing to the UNDAF-Bangladesh outcome “Societal changes are realised to reduce discriminatory practices and to pursue equity and empowerment for women and girls” which subsequently leads to improved human security and poverty reduction. They are: I) policies and legal framework aimed at preventing violence against women, protecting and supporting survivors adopted, implemented and monitored; II) social attitudes and behavioural changes effected to reduce violence against women and discriminatory practices; III) conducive environment created and capacities enhanced for providing support and care for women and girls who are vulnerable to, and/or have survived, violence.

This project, financed by the MDG Spain fund, is facing delays in its commencement. However, out of the 11 implementing ministries (supported by 9 UN bodies), the Ministry of Social Welfare has just recently been commenced its first quarter of implementation.

In general and as commented in previous chapters, the UNFPA projects including the joint programmes appear to work in isolation from each other and therefore it does not appear that there were linkages made between the CP components, let alone between the CP components and the joint programmes.

The joint programmes might have brought the UN agencies closer to each other, although some animosities were created during the process of the design and implementation of “Accelerating the reduction of maternal and neonatal mortality and morbidity”.

Pilots, innovations and testing are useful under the conditions that a pilot would be contributing to a particular national policy debate. If this is the case, then the design and plans of such pilots should ensure, before commencing, that pilots are carried out with added value for national policy and strategy makers, i.e. to be carried out at the right time and sequence to feed into national deliberations. Only when national debates require evidences or when a colleague on national level is energetically follows up for national think tank, a linkage can be made between the experiences of additional projects and programmes.

Operational research can be and is used for policy debates, strategy designs, quality assurance, programmatic prioritisation and utilisation of information systems. A more strategized use of operational research would benefit the needs of national debates.

A further linkage might rather be a constraint: the capacity of the UNFPA office should be adequate to contribute to joint programmes, in particular when UNFPA intends to take the lead.
2.3.8 COMMENTS ON EMERGING ISSUES

The UNFPA reporting format foresees comments on emerging issues, like climatic changes, urbanisation, refugee population, emergency/disaster preparedness, humanitarian response during disasters. Based on the documents and information received, the comments by the ET are limited.

Climatic changes

Global climate change has affected Bangladesh resulting in changes in temperature; rising sea level, intense floods, droughts, and storms. The number of climate change refugees is increasing in the southern part of Bangladesh, and it is said that about 35 million people will be displaced by 2050 (The United Nations Intergovernmental Panel on Climate Change estimates). Climate change is also likely to affect world’s food supply, and scientists predict that world harvests will drop 20 to 40 percent by the end of this century. This figure could be higher for Bangladesh. The climate issue has received a wide attention and importance, and Bangladesh took part in all major international meetings/conferences related to global climate change. The State of the World Population Report 2009, published by UNFPA, was widely circulated in Bangladesh and has received huge attention and interest in population and climatic changes. In addition, a number of policy dialogues were organised involving policy makers, Parliamentarians and civil societies and programme planners to create an enabling environment on population and its impact of climatic changes.

Urbanisation

Like other developing countries, urban population growth is rampant. Bangladesh has 27% urban population, increasing at a rate of 6% because of rural poverty and natural disasters. The capital city Dhaka is one of the largest cities in the world. Rapid transformation in urban areas increased social unrest and urban violence through creation of poverty, homelessness, environmental deterioration, social exclusion, intolerable living standards and spatial segregation. To understand the changes more studies has to take place on spatial inequalities, urban population dynamics, urban housing, health and sanitation, the relevancy of urbanisation and spatial development theories is of immense importance. UNFPA is responding to these changing challenges so far through its project “RH Interventions in Urban Settings”.

Refugee population

Bangladesh hosts more than 200,000 Rohingya refugees from Myanmar. Many of them are living here for close to twenty years. The Bangladesh government divided the Rohingya into two categories - recognised refugees living in official camps and unrecongnised refugees living in unofficial sites or among Bangladeshi communities. While camp residents have access to basic services, those outside do not. With no changes inside Myanmar in sight, Bangladesh must come to terms with the long-term needs of all the Rohingya refugees in the country, and allow international organisations to expand services that benefit the Rohingya as well as local communities. UNFPA, through a national NGO (RTM), is addressing the RH needs of Rohingya Refugees in the south-eastern part of Bangladesh.

Emergency/disaster preparedness and humanitarian response during disasters

The ET does not assume that information in this section is complete. It is based on relevant information available to the ET, i.e. the UNDP website and UNFPA annual reports.

Bangladesh faces disasters every year, and about 42,000 volunteers of Bangladesh Red Crescent Society’s Cyclone Preparedness Programme are mobilised in the coastal belt before a severe cyclone. During the past years, disaster management activities have been strongly supported by a financial and technical assistance project of the UNDP. The Comprehensive Disaster Management Programme (CDMP) is helping improve coordination in response to disasters at all levels. The Ministry of Water Resources created the Water Resources Planning Organisation (WARPO), a key organisation in dealing with the nation’s water resources planning and management. One of the significant achievements of WARPO is the formulation and adoption of the Coastal Zone Policy (CZP), designed to maintain coastal dykes as a first line of defence against storm surges, while encouraging the forestation of dykes. A Disaster Emergency Response (DER) exists within the LCG on Emergency. In addition, WHO and DGHS co-chair the Health Subcluster which meets on a regular basis to develop preparedness measures and the report State of World Population 2010 focuses on Gender and Natural Disasters.
UNFPA supports the response to Flood and Cyclones during the 7th CP through the provision of hygiene kits and boats, etc., some capacity building activities (MISP training), and Post AILA response (UN Joint assessment, CSBA refresher training in AILA affected areas along with the distribution of RH kits). In recognition of the rather ad hoc response, CO recruited a humanitarian response officer who arrived in early 2010 to set up more sustainable system to respond to the recurring emergencies in Bangladesh. A preparation of CO emergency preparedness and response plan and and standard operating procedures have been initiated.

2.3.9 Harmonisation and Alignment

Alignment

The Government of Bangladesh has expressed its commitment and support to the UNFPA’s programme in Bangladesh. The Prime Minister in her meeting with the UNFPA Representative reiterated for UNFPA’s leadership in providing support and assistance for maternal and RH programme in the country. She expressed her enthusiasm for an essential RH package to be delivered at the community clinic level and above.

The 7th Country Programme of UNFPA is well aligned with the national policies and strategies, and with the Millennium Development Goals (MDGs) and PRSP. It is harmonised with the national policies and strategies as follows:

The National Health Policy was approved in 2000, and is currently (still) under revision. As the policy aims to improve health and nutritional status of the population with public health and basic medical services, the UNFPA’s programme, particularly the fistula project, family planning, ASRH, and SBA for safe delivery directly harmonised with it. The draft of the new health strategy foresaw to intensify safe deliveries through efforts in widening and deepening the SBA network. This was strongly and controversially debated and the “H4” (WB, WHO, UNCEF, UNFPA) advocated for concentrated investments in fully trained midwives which is reflected in the revised draft.

The National Population Policy is written considering current and longer-term implications of continued population growth. The focus of the policy is to reduce unwanted fertility, counteract the effect of population momentum and to avoid childbearing in adolescence. The UNFPA programme is aligned with this policy.

The National Policy on HIV/AIDS and STD approved by the government in 1996, aims to prevent HIV transmission, reduce the personal, economic and social impact of HIV/AIDS, prevent transmission of sexually transmitted diseases (STDs) and provide STD management. The UNFPA programme is aligned with this policy.

The government has adopted the National Strategy for Maternal Health in 2001 with active participation of private practitioners, professional bodies and NGOs. The Strategy aims to strengthen the provision and use of Emergency Obstetric Care, improve the nutritional status of women and girls, ensure high-quality and women-friendly services and bring about positive changes in perceptions and behaviours to support women in their right to safe motherhood and a life free of violence and discrimination. A revised Maternal Newborn Child Health Strategy is planned with a review of the existing one. The UNFPA programme is in aligned with both of these policies.

The MoHFW’s Gender Equity Strategy, 2001, (GES) links the Strategy for Maternal Health with a wide range of strategic objectives influencing across the MoHFW, health and family planning services in line with the GoB’s National Action Plan and National Policy for Women. The UNFPA programme is in alignment with this policy as well.

Bangladesh participated at the Millennium Summit in 2000 and committed toward sustaining development and eliminating poverty will get highest priority. The health programme objectives of MDG is directed at improved maternal health, reduced child mortality, reduced fertility and disease control, and effective control programmes for HIV/AIDS, tuberculosis and malaria. The UNFPA programme is in alignment with these goals of MDG.

A time has been fixed to achieve the MDG goals: indicators of 2015 will be compared with 1990. The Declaration pledges explicitly “to combat all forms of violence against women and to implement the Convention of the Elimination of All Forms of Discrimination against Women (CEDAW)”. It recognises
the importance of promoting gender equality and women’s empowerment as an effective pathway to combat poverty, hunger and disease and for stimulating truly sustainable development. Although Bangladesh has ratified the CEDAW declaration there are reservations in two of its articles (article 2 and 16.1(c). As CEDAW is a complete legislation to ensure women’s rights and gender equity, and the parts of it are inseparable, reservation in any section will jeopardize the major purpose of the convention. Women activists and academicians are still working towards withdrawing the reservation on CEDAW, UNFPA, as the leader of the UN thematic group on gender is considered as vital development partner.

Harmonisation

The UNFPA in Bangladesh maintains proactively close relationship with the donors having offices in the country. UNFPA is a member of the HNP consortium, a Local Consultative Group (LCG) of the donors, and support the Health Sector Wide Approach (SWAp) by contributing to the “Pool Fund”.

The UNFPA Representative chaired the HNP consortium for one year and UNFPA is now participating as a member. The HNP consortium has a number of task groups consisting of selected development partners (DPs) and government officials to track the progress of the sector programme (HNPSP) and to inform the design of the new programme. UNFPA is the DP lead for the MNCH task group, which provided an opportunity for UNFPA to contribute to and lead the policy level discussion.

UNFPA is in the “theme group of AIDS” in the UN system. UNAIDS is the convener of the group. As a member of this group, UNFPA works for the AIDS portfolio and is assigned to work with sex workers and supports the GoB and CSOs with technical expertise. UNFPA, jointly with UNICEF and WHO, is implementing the above mentioned initiative on "Accelerating reduction of Maternal and Neonatal mortality". The initiative is funded by DFID and EC. A survey on maternal mortality has been planned under the HNPSP, and the GoB jointly with UNFPA and USAID are funding and International Centre for Diarrhoeal Disease Research, Bangladesh – (ICDDR,B) is conducting the survey.

A common UN country assessment (CCA) has been conducted in 2010 using the MDG assessment as the basis of UNDAF. Seven National Pillars have been suggested in UNDAF in the line of National Priority mentioned in the National Women’s Advancement Policy (1997, revised in 2007) and Five Year Plan. The pillars identified by UNDAF include: 1) Demographic Governance and Human Rights; 2) Pro-poor Growth and Equity; 3) Social Service for Human Development; 4) Food Security and Nutrition; 5) Climate Change, Environment and Disaster Risk Reduction; 6) Pro-poor Urban Development and 7) Gender Equity and Women’s Advancement. As UNFPA has long been working on RR and RH related issues it has already been identified as a women-focused development partner. UNFPA has already been assigned as the convening and lead agency for the UNDAF pillar 7 (gender) as well as outcome 1 / output 1 (health) of pillar 3.

UNFPA has been designated as the UN Focal point among the nine participating UN agencies for the UN joint programme “Addressing Violence Against Women in Bangladesh,”. The joint programme involves 11 Ministries of the Government of Bangladesh.

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50 There are 10 members in the group consisting of UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and World Bank.

51 The NAP was first developed in 1997, which emphasises gender equity in access to resources including property among others. This has created a debate among the fundamentalists (as the equitable access to resources/landed property goes against Islamic “Shariah law”) and women activists. With the continuous pressure from the fundamentalist group the BNP government has revised the NAP, taking out the part on “gender equity in access to resources/property” in 2004. The debate was continued in this regard and in 2007 the Caretaker government revised the NAP according to 1997 document, which has been accepted by the present government with minor revision. However, the NAP is yet to be officially declared by the government and is not circulated to the mass.
2.4 CONCLUSIONS

The outcomes of the 7th Country programme are based on the success of 1) the implementation of multiple projects and 2) policy advocacy and contribution to sector wide approach at national level; and 3) joint programmes.

The numerous projects were largely effectively implementing what they were asked to implement through their design. A long list of activities was completed, programmatic contribution provided and UNFPA engaged proactively in policy debates as well as in donor coordination.

Technical advice contributed to strategic direction documents for strengthening midwifery services in Bangladesh (which is a milestone document for midwifery cadres as per ICM standard in Bangladesh for the first time in its history), UNFPA advocated for the two-fold strategy to increase skilled birth attendance and has been supporting the in-service midwifery training for the existing nurse midwives. The curriculum was also developed for this purpose.

A strong weight was given to knowledge transfer to various cadres of staff (parliamentarians, personnel in the health sector and of the MoWCA, staff of other ministries, imams and religious leaders, journalists etc.) as well as targeted awareness rising, orientation and sensitisation, which included FP, RH, adolescence sexual and reproductive health, gender equity to some degree, GBV, dowry and early marriage.

A variety of communication means were used, including print material, support of various peer groups, interpersonal communication (as e.g. the Part Time Field Motivators), mass communication means (drama, music, folk singers etc) and are very likely to have brought about changes in the level on awareness and possibly mindset. An objective assessment to which degree each communication mean had or can have an effect would be still subject to a special study.

The evidences on increase of some key indicators such as CPR, ANC visits, skilled attended deliveries, in the two zilas in which UNFPA concentrated its efforts, cannot necessarily be directly linked to UNFPA because of the improvement of the GoB’s own efforts and the input of other actors. However, it is fair to state, that UNFPA had effectively contributed on outcome and possibly impact level. The fact that UNFPA’s specific role cannot be well shown shall not be understood as a negative sign as such, because it depicts the sense of harmonisation with the GoB.

The project have contributed in ensuring reproductive health information and services as it has been provided throughout decades in Bangladesh. These efforts might have impact at output levels to increase demand and provision of services for reproductive health. However, the 7th CP had never aimed to enable the GoB in a sustained manner to be effective in managing emerging situation and reaching national targets for contraceptive use, reduction of maternal mortality and morbidity particularly for UNFPA outcome targets as well as for MDGs.

UNFPA focus and capacity has been thinned by multiple and largely incompletely designed projects, such as no action has been taken to comprehensively materialise strategies on ASRH and communication; SBAs are performing deliveries without supervision by MoHFW; the youth programme is limited within small coverage and not enough activities taken to empower them; fistula interventions are taken up with inadequate awareness building and counselling support; and interventions for brothel based sex workers and transgender persons are not directly linked with interventions for youth programme in two zilas.

The support to the DGFP is not sufficient to strengthen human resource management to minimise vacancies, absenteeism and dissatisfaction among staff. The quality of care could not be ensured due to lack of appropriate monitoring and evaluation system and thus make the facilities fully functional. The
Directorate still needs technical assistance for designing and producing effective communication materials.

The zila located UNFPA office assistance is limited to assisting in implementing specific activities of the IPs like organising trainings and observation days, arranging community meetings and acting as resource persons in training sessions. However, there is no role observed for providing technical assistance for improvement of management efficiency and effectiveness at zila and upazila level including planning, monitoring and evaluation at national and zila/upazila level. As a result, UNFPA was overly preoccupied to ensure the implementation of project activities rather than building sustained systems, providing technical assistance and thus losing the leadership in fertility reduction.

Gender (not only women) equity and empowerment is needed for meeting RH needs (esp. youth). For example, the “Life Skills Based Reproductive Health Education for in-school Youth and Adolescents through Peer Approach” (RH project implemented by the DSHE/MoE) deals with the in-school young people/adolescents through institutional mechanism in Sylhet and Cox’s Bazaar. The number of schools in the project area was 20 in Sylhet and 20 in Cox’s Bazaar adding 20 more schools in 2010. About 18,500 adolescents including Boy scouts and Girl Guides have completed the programme (Hossain, KMH, UNFPA, December, 2010). It would have been better if the project activities had been performed in close collaboration with gender component.

The gender component addresses MDG 3, CP, ICPD and is linked with the National Action Plan for Advancement of Women (NAP) priorities. The projects of the component attempted to address the gender and RH related awareness issues through involving people in different categories in various locations However, the activities undertaken by the component are inconsistent with output and outcome indicators. The output indicator 1 refers to sensitisation of community leaders and decision makers without addressing women and girls as well as the larger community who need to be made aware. Reliable data on gender based violence for the indicator 2 were not available with the project management. Indicator 3 is not specific to the outcome. Moreover, within UNFPA the gender component works without much linkage to other components.

The component involves both women and men, girls and boys, workers and owners, provide care to children, (which are very much useful. However, as the results are reported only in annual progress or activity reports, it is difficult to make comments about the qualitative changes brought by the project.

Although the programme has a well structured monitoring mechanism with specific tools, none of the projects has used it. Absence of gender disaggregated data, proper monitoring, lack of coordination amongst the different projects, absence of impact assessment and other factors limit the scope of identifying significant impact of any of the project of gender components.

The gender component can be termed as “incomplete programming” as most of the projects are on raising awareness rather than performing any practical action towards ensuring gender equality or women’s empowerment. With this limitation the contributing effect to the set priority is minimal. Most of the activities of the gender component are related to other services promoting RH without developing a holistic view of the issues.

It must also be mentioned here that gender is not mainstreamed within UNFPA as there is no gender policy for the country office. However, a common UN sexual harassment policy is followed by the staff.

The programme with the parliamentarian is new and should continue to operate for few more years, before handing the activities to a research wing of MoHPFW. As parliamentarians are extremely busy people, effort should be made to ensure their greater participation in all the project events by continuous persuasion and reminder for them to attend. Meanwhile, UNFPA should identify with UNDP complementary and hereby mutually optimising interventions.

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52 The goals of the NAP are: i) to make women’s development an integral part of the national development programme; ii) establish women as equal partners in development with equal roles in policy and decision making in the family, community and the nation at large; iii) to remove legal, economic, political or cultural barriers that prevent the exercise of equal rights by undertaking policy reforms and strong affirmative actions and iv) to raise/create public awareness about women’s different needs, interests and priorities and increase commitment to bring about improvements in women’s position and condition.
Activities of three P&D partners, namely Planning Commission, Department of Population Science and NIPORT are overlapping. All of them are engaged either in conducting their own research or contracting them out to third party. They also do policy briefs, and dissemination of research findings, and involved in training activities. There has to be coordination among the three organisations in presence of UNFPA, and each organisation take a specialised and focused activity, like (a) research, (b) policy briefing and dissemination, or (c) capacity development and training.

Most of the planned work to prepare BBS with staff training for collecting RH and gender related information, and putting in place a geographic information system unit is completed. BBS should now do this work all by themselves. However UNFPA should maintain technical support to BBS in areas to conducting census in 2011, and on data analysis disaggregated by age, sex, economic status and location.

In turn UNFPA did participate in technical fora, but did not or was not perceived by some partners to assume the role of a lead agency in RH, fertility reduction and gender agenda, while at the same time increasing its visibility in high levelled debates and UN and bilateral coordination, the LCG, debates through a proactive engagement.
3 Lessons Learned

This chapter shall not be a reiteration of the elaborations above. It rather focussed on a few key issues. Upfront it shall be re-stated that the completion by UNFPA of a high workload, multiple tasks and activities are recognised and appreciated.

Programmatic lessons

Even in rather small scale the 7th CP demonstrated cooperation between the public and private sectors in partnerships, as the service deliveries for example through NGO urban health centres or through the centres operated by the profit making sector. At the same time these interventions, due to their varying degree of quality in performance) underline the need of quality assuring and regulatory role by the public sector, which requires strengthening.

Various communication mean were used to mobile households, families, youth and individuals. It appeared that the most effective mean is the communication directly with individuals and households. The “Part Time Field Motivators” present such a cadre which are part of UNFPA’s supported interventions. As it can be observed it many similar settings (in and outside Bangladesh) the so called “grass-root” actors show often a high degree of motivation, sense of altruism and ambition to carry agendas forward for the society and neighbourhood they are living in. A study on the effectiveness of the communication means could make an objective assessment. Subject to the outcome of such study it can be considered as a successful and promising trial, while it needs to be discussed how such a cadre will be financed and whether a ministry is the best “home” for them or rather a CSO.

A few print products appeared appealing and were appreciated: the flip chart on FP, RH, safe motherhood, HIV/AIDS and gender is useful for Family Welfare Assistants (FWAs) as a ready reference for use in counselling couples. See further comments below on other print media more in general.

Programmatic successes face the challenge that the progress in the health system has to be able to cope. An increased utilisation through successful interventions on the demand side (through the voucher system, awareness creation, home visitors) requires the supply side to be ready. Hereby human resources present the most difficult component which of course is beyond UNFPA’s scope. However it underlines the importance given by UNFPA to link up with the relevant authorities in the GoB and with other actors in and outside the UN agencies.

Contracting health staff into the public sector was piloted in the joint programmes and showed so far positive effects while the question on financial sustainability has to be still answered systemically.

Several interventions aim at reducing immediate human suffering such as victims/survivors of GBV and fistula patients. It is very worthwhile to support such interventions, especially when the numbers of affected people is high and/or the level of suffer is severe, while at the same time systems are developed which can be expected to have a medium or long term effect in the prevention and treatment of these problems and conditions. Therefore a balanced approach can be promoted between systems building and immediate assistance.

RRF

The lessons learned from the 7th CP confirm that a well thought through RRF is essential. The inconsistent RRF of the 7th CP had major consequences throughout the period of the CP. The UNFPA got overwhelmed in following up and implementing projects rather as stand–alone interventions and to a large degree the activities were carried out as planned in the AWP. But in absence of committed common programmatic strategies, the direction remained unclear.

The 7th CP also shows the significance of correct timing of the steps in the project management cycle, including the reviews. The MTR was carried out late in the CP cycle and, although the MTR pointed out the weaknesses, there were hardly options to act during the life time of the projects. Inevitably the RRF was of limited use for ongoing monitoring, equally for the final evaluation. Therefore monitoring was not done systematically, which led to the existing gap in evidence for success and/or constrains in the projects and timely adjustments of the intervention. The unclear UNFPA strategy – and possibly an office
which needed time to recognise the need for and to find its place beyond carrying out intervention – also resulted in the programmatic strategies being not, or only insufficiently developed.

Incomplete programming

Well thought through planning is essential and planning gaps become visible at least during a retrospective review: notwithstanding that the UNFPA office was largely busy and fulfilled numerous tasks, relevant for the RRF, the individual projects were designed rather based on historical background than on updated situation analyses and needs assessments. The interventions were/are rather “more of the same” than moving in a joint strategy. Although all components are well aligned with country polices and priorities, they seem to a large degree to be incomplete in their concept, as well as in their implementation. A few examples are listed:

- The gender component addresses mainly awareness creation of GBV, dowry and early marriage, which are surely priorities and present a useful starting point and works eventually towards equity. However major pillars in the gender agenda, as mainstreaming, empowerment, access of women to work, services and resources, decision power sharing in household, social life, should be conceptually captured and indicate if and how the awareness creation is contributing.

- In providing care for victims/survivors of GBV with shelter and food psychosocial care, empowerment for income should be included not only in some cases, without which the question has to be raised whether the victims are indeed assisted in getting out of those problems which brought them into the situation in the first place. Similarly, fistula patients get access to operations, which of course is essential for them. But, especially those women who get unsuccessfully operated and also their husbands require also accompanying or alternative assistance to deal with their situation.

- SBA training and awareness creation alone cannot reach the level of attended deliveries as stated in the related outcome. An essential additional element would be “gender”, not “women” empowerment (e.g. decision making power to access services, rights for their own (reproductive) health) which is required to meet RH needs. Without a comprehensive situation analyses on gender, and its relation to RH, plans might stay overly optimistic and not reaching its envisioned outcome.

- If a geographic focus is chosen, then an area (in this case the zilas) specific analyses of the situation, its constraining factors, problems and gaps as well as openings, opportunities and facilitating could indeed make use of the approach and address the specific characteristics of the zila.

- Similar counts for target specific needs and approaches: RH promotion would better also address pockets, especially the youth, poor, teenage couples, difficult to reach areas, social pockets like minority groups, host communities residing in the neighbourhood of refugees (should rather be named “affected areas”).

- The development element of “population and development” should support MoWCA how to incorporate population and gender issues into the development of the sector and systems. This “gender mainstreaming”, even though expressed in descriptive phrasing, was rather aimed at through separate projects, which again would be less able to build the capacity in the relevant line Ministry to assume its mandate and responsibility. Eventually gender mainstreaming was not streamlined and addressed by neither component.

- While the programme documents state that poor and vulnerable groups are target groups with special importance, the conceptual framework would rather be complete if poverty profiling had been adequately addressed through the current CP.

- If trainings, orientations and alike remain one – off actions, as well as research and studies not leading to programmatic or policy decisions, than their added value are questionable and the funds are likely not to be well spent (“value for money”).

Quality assurance

The 7th CP shows that a lack of a functional quality assurance system can have multiple consequences. The “incomplete programming”, the details of some activities, the limited use of monitoring as a
management tool raise questions how and to which degree UNFPA aimed to ensure the quality in all aspects of its programmes and activities carried out and/or funded by UNFPA. Some, if not all of the incomplete programming could have been avoided, equally the details of implemented activities.

**Monitoring**

It can be learned from the lack of or lack in use of a monitoring systems that almost automatically multiple constraints are caused. Monitoring should be an inbuilt element of each intervention and its management. A monitoring system should not only be in place but also be used which is the responsibility of each individual officer. In cases where projects are managed by the partners, the project itself is dependent on the M&E system of the partner. However, it would be UNFPA’s role to observe whether a partner has an adequate monitoring system functioning and to take action and support them when needed. This could be an example to assist partners in a sustainable, capacitating approach, focussing more on the institution than on individuals.

In this light also analyses of finance and programme data should be part of routine, not limited and dependent on events like an evaluation exercise.

**Pilots**

The 7th CP contains pilots with interesting results to be expected. However the purpose and the use of the pilots remained not really clear. Although the following could be considered as a further example for incomplete programming, the usefulness of pilots is mentioned as a separate point. If it is considered to conduct a pilot, either as a type of activity, in a specific programmatic or geographic focus, then it has to be first ensured that the pilot would be contributing to a particular national policy debate. And if so, then the design and plans of such pilots should ensure, before commencing, that pilots are carried out with an added value for national policy and strategy makers, i.e. to be carried out at the right time and sequence to feed into national deliberations. This implies that the mechanism how a pilot will be used and contribute should be clearly identified from the onset53.

**Coordination and cooperation**

The 7th CP intends to achieve outcomes as one country programme. In addition to the need of thorough planning and monitoring the 7th CP also depicts that ongoing close coordination as well as cooperation within UNFPA as well as with partners is essential for optimising not only the effect of a particular project but the cumulative effect of all interventions of UNFPA. The UNFPA projects and to large extent the components are still functioning in programmatic isolation. Mutual benefits and linkages are better ensured in fluent communication and collaboration than through formalised coordination meetings. This is not to undermine the importance of regular coordination meetings within UNFPA and between projects, but should emphasise the responsibility of each staff member to be proactive and willing to link up on her /his initiative with colleagues based on professional judgement and ambition, not dependent on personal preferences.

Project specific examples could be given from all components, like in the P&D component where research and trainings are overlapping between three institutions which are involved in research.

Hereby also intra-UNFPA cross-components lessons are not well captured. For example, the staff cadres/volunteers who are reaching personally households and individuals present good experiences in urban health for identifying poor, ensuring services for poor and innovative systems for M&E. This positive experience and learned lesson is not well used for conceptualisation.

**Management set up**

UNFPA continues work through a project approach, which slowed the process to think in programme terms. The high number of projects put a cumbersome burden to follow up the projects managerially and is likely to require higher transaction costs. A drastic reduction of numbers of projects and applying alternative modes of cooperation could be of better use of funds and personnel. The preferred modes of

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53 For example: the 7th CP focused on two zilas without having the mechanisms in place to systematically capture and use the experiences. Similar, the UNFPA funded “field-motivators” of MoWCA seem to have a significant role; however the lessons are not systematically captured and the future role and funding is dependent on UNFPA.
cooperation would be a case by case decision, for example trainings and research could be rather subcontracted than having separate projects with research and training institutions.

Management of project staff, procurement, approvals and fund release by the UNFPA is highly bureaucratic and disbursement delays, which are reportedly longer and processes slower than in other UN funded projects implanted in the public sector.

It is in the nature of some terms or phrases that they can be interpreted quite differently and in a broad range. While formally decision making in the UNFPA projects is decentralised to PDs, it often appears that this “decentralisation” is rather nominal while decision making stays largely in the hands of the UNFPA office, some projects also facing a micro-management. This management set-up or its interpretation is in reality risking undermining the Ministries taking responsibility.

Given the long history of work through NPPPs their effect should be analysed more thoroughly. During the evaluation the ET perceived that NPPPs are often, although not entirely, used for fulfilling administrative and organisational tasks. Even if working technically, the NPPPs are frequently rather considered as an additional office staff and hereby acting on behalf of their colleagues, less so assisting in the sense of coaching their colleagues in the Ministries. It might be worthwhile (see under recommendations) to review their role and TORs in a separate organisational review.

In line with the UNFPA internal coordination and communication, the office could develop its “office culture” further from a commanding to a supporting culture. Given the mandate and the nature of UNFPA the NPPPs and the zila sub-offices should rather be in the forefront of decision making then to be executing decisions.

Interpersonal communication

Notwithstanding the value of the variety of communication means in raising awareness, the personal interaction of households with home visitors of the various departments, organisations and institutions seem to be most appreciated by the households and present an influential approach. A comparative qualitative operational study could verify and bring an objective view.

Civil Society

So far NGO and no Civil Society Organisations (CSO) involvement was minimal and UNFPA might be missing out the perceptions and views of the civil society in its advice to national policy and strategy design. In its institutional capacity building efforts UNFPA could well include a focus on CSOs including support in service provision and activities. For example, the “field workers” appear very effective, but it is debateable if this is the role of public sector.

In summary

In a brief summary it is fair to say, that UNFPA have been engaged with its 7th CP in Bangladesh in a large variety programme-, policy-, strategic interventions which all, individually assessed, have to be considered useful and benefitting, while many lack coordination, completeness and/or quality. This should not be understood as questioning the relevance of the interventions, rather as pointing at the need for a common strategic direction, collaboration (within UNFPA) and an overstretched CO which requires investment in its capacity and strategy.
4 Recommendations

The ET was requested to come up with recommendations for the 8th CP, (not operational recommendations for the 7th CP). Therefore this chapter is directed to UNFPA only.

UNFPA's Concept for the 8th CP Development

The 7th CP had incorporated a wide range of issues and themes. The experience over the last year have shown that UNFPA's investment were too thinly spread in respect to the capacity of UNFPA Bangladesh to make a clear difference with the required standard and state of the art. UNFPA might wish to concentrate and streamline its efforts to the most pressing and priority issues in the country ("what is most needed"), corresponding to priorities set by the GoB ("what is most wanted") and in reflection to the mandate of UNFPA ("what we can do best").

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

**Figure 2: Possible Concept for 8th CP**

MoH&FW and MOWCA in the forefront and aims at enabling these Ministries in resuming their responsibilities. It was argued that the concept “looks more like a generic model which could be recommended to the grass-roots organisations as well”. The ET would not see a contradiction, to the very contrary, if a “grass-root organisation” would have a similar concept. However a CSO is not likely to be in the position to address institutional capacity building or high levelled policy debates and advocacy.

The following explains and elaborates on the concept’s use of UNFPA's comparative advantage. It is also suggested that the UNFPA's role should move on and transit during the last year of the 7th CP from the current direct involvement in activities and position itself rather as a strategic, visionary, institutional supporting agency, while the needs of women in immediate needs due to GBV/VAW and gender inequality should be responded to.

In this light it would and should be the role of UNFPA to assume the position as the lead agency in the debates in FP/RH and gender.
TABLE 12: KEY ACTORS IN A POSSIBLE CONCEPT FOR THE 8TH CP

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<thead>
<tr>
<th>Blocks</th>
<th>Reduction of Fertility</th>
<th>Gender agenda</th>
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<tr>
<td>A. Institutional capacity building</td>
<td>UNFPA, TA</td>
<td>UNFPA, TA</td>
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<tr>
<td>B. Advocacy on policy and political level</td>
<td>UNFPA</td>
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<td>C. Creation of critical mass for change in</td>
<td>Civil Societies</td>
<td>UNFPA</td>
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<tr>
<td>attitude and behaviour/ mainstreaming</td>
<td>UNFPA to enable</td>
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<td>MoH&amp;FW to scale up (TA</td>
<td>MoWCA to</td>
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<tr>
<td>D. Empowerment incl. support to women in</td>
<td>Civil Societies</td>
<td>Civil Societies</td>
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<td>need</td>
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Accompanying mechanism

The agendas need to be supported and accompanied by the continuation of the proactive presence and lead of UNFPA in debates and fora of development partners (LCG), UN and UN/DP/GoB relations and debates.

Hereby it is advisable to continue UNFPA’s contribution in the SWAp pool.

ADDITIONAL EXPLANATORY RECOMMENDATIONS

Fertility Reduction/Family Planning

Reproductive Health remains a particular concern in Bangladesh. As stated above, until the capacity of the UNFPA office is elevated, UNFPA’s assistance in the RH component needs to be focussed. The country is facing a pressing need to reduce its population growth in the country, with its multiple effects including effect on maternal health, while it has been quite successful to reduce the fertility rate over the last decades from over 6.

However the current level is still too high and is rather stagnant, although TFR has re-started to decline and CPA to increase. It will require additional, probably even more challenging efforts to get the trend into a downward curve. This will require updated, in depth knowledge and thoroughly thought through approaches taking into account the demographic changes in country, in particular the urbanisation of poor and ultra poor part of the population, teenage couple and hard to reach pockets. Elements to consider encompass:

- Support technically and financially the GoB to get to know in depth the fertility (“know your fertility”) in Bangladesh - conduct inventory of already existing knowledge on socio-cultural-economical and behaviour aspects impacting on gender relations and fertility reduction.
- Support technically and financially the GoB to conduct and utilise anthropological/sociological and follow up studies to address identified gaps on the knowledge of fertility related factors in Bangladesh including the link between gender and fertility rate.
- Support technically and financially the GoB to document lessons learnt in public and private sectors and by CSOs in dealing with these socio-cultural and economical factors.
- Support technically and financially he GoB to promote and scale up the best/good socio-cultural practices that reduce fertility.
- Support technically and financially CSOs to implement promising interventions in the area of socio-cultural attitudes and practices impacting on fertility and the link between gender and FP.
- Support technically and financially the GoB and NGOs to mobilise men, women and communities for positive behavioural and attitudinal change impacting on fertility reduction.

Gender

The gender agenda is to be understood by the UNFPA office in its entirety, whereby RH/fertility and gender present of course mutually related issues. However the gender agenda can only be addressed when
first all elements are known, described and a comprehensive concept is designed. It might well be that UNFPA chooses to address only some, focussed, elements, however well defined and clarifying who and how the other elements are dealt with by the GoB and/or other agencies.

It is required, similar to above, that the UNFPA undertakes similar efforts to assist itself and the MoWCA in applying a "know your gender agenda in Bangladesh" approach. This does not imply to re-do or duplicate already existing studies, analyses and knowledge. It has rather to identify and address the knowledge gaps as the basis for further actions.

**THE FOUR “BLOCKS”**

**Institutional capacity building**

Institutional capacity building (support in building up the capacity in policy and strategy formulation, M&E and management systems and delivery systems) is rather likely to have a longer lasting and sustained effect if approached systematically, prioritised and with a logic sequence. The following steps could be considered:

1. Validate, update and/or conduct institutional capacity assessment and follow up studies to carry the gender and fertility agenda forward.
2. Review and address existing policies, strategies and institutional coordinating and governing arrangements and processes (including working groups and coordination mechanisms of development partners, institutional position and role of gender focal points/positions).
3. Provide technical and organisational advice to the gender sector development in view of sector wide programming (governance, technical working groups, policy, strategy, plan, budget, support/supervision, monitoring).
4. Based on an updated review, prioritise and collaborate with the respective body (MoWCA, MoHFW) to develop and/or consolidate sustained management systems, tools and processes (as e.g. procurement and finance management systems, human resource management and career planning, strategic and joint operational planning, information systems, M&E, quality assurance, physical assets and commodities management, programme implementation management).
5. Provide continuous management and technical expertise for MoWCA and MoHFW.

Capacity building of Civil Society Organisations can be considered to enable them to participate in possible calls for proposal and manage the proposed interventions.

**Advocacy on policy and political level**

Advocacy is meant to be understood as the information and opinion and decision formulating actions for decision makers of larger scaled political, economical and public opinion influencing bodies, offices and individuals. The term “advocacy” should not be interpreted as general awareness creation (as it seems currently to be the habit). Advocacy will require good quality data for mainstreaming fertility reduction and gender policy issues, and for R&D in the running programming.

Piloting can be positive learning from testing, trying out new interventions and can contribute for evidence based “advocacy” provided that pilots are indeed linked to national debates and mechanisms are identified and used to capture these learning.

**Creation of a critical mass for change in attitude and  behaviour /Capacity for mainstreaming**

Fertility reduction and gender concerns are indeed crucial issues for Bangladesh. Therefore there issues have to be addressed from all possible sides, with relevant players and with well designed strategies with a common vision. This “block” should have the options to work with various players, CSOs and well as the Ministries, however in a supporting and not replacing role.

Similar to above, mainstreaming will also have more likely a longer lasting and sustained effect if approached systematically, prioritised and with a logic sequence. The following elements could be considered:

1. Support technically the GoB to carry out a situation analysis and follow up studies to develop a consensus on priority key sectors to be addressed.
2. Based on the above identify sector specific (including MoWCA) fertility (based on “knowing your fertility”) and gender analyses, institutional and organisational needs and opportunities for gender mainstreaming as well as creating a critical mass of couples willing to move from awareness to change of attitude and behaviour.

3. Assist technically the GoB in the design/review of sector specific reporting framework at all levels, monitoring and evaluation mechanisms, including gender specific indicators and gender disaggregated data.

4. Lobby and assist MoWCA in lobbying in line ministries and sectors for political support and resources for gender mainstreaming activities at union, upazila, zilas and national assemblies. The role of UNFPA should rather be to assist technically MoH&FW and MoWCA in their fertility reduction advocacy and gender mainstreaming efforts than to do the mainstreaming directly itself. Therefore UNFPA could assist on high political level to translate commitment to adequate budget allocation and inclusion of activities in partner Ministries.

**Economic, Social and Legal Empowerment**

Zila specific situation analyses and follow up studies could assist in indentifying rather zila specific need and options than applying a centrally standard approach.

1. Provide financial and managerial support to empowering initiatives and provide direct assistance to people in need due to gender relation by Civil Society Organisations. Civil society might in the better position than public sector or development partners and agencies to recommend and come forward with possible approaches which might create and/or carry existing awareness forward to change of attitude and behaviour. This could be triggered, promoted and supported through a call for proposal of Civil Society Organisations.

2. Based on operational research on quality and effectiveness of the above mentioned various communications means continue to produce and disseminate sector and target group specific BCC messages and materials to lobby for increased women participation in decision making and strengthen partnership between women and men (e.g. involvement in household work, subsistence farming, cash control etc). The materials have to reflect much more the educational requirements and the target group than the existing material largely presents. Consider life-skills multi-media edutainment in fertility reduction, gender equality and equity (incl. non-violent conflict resolution) for boys and girls in primary school.

On central level links can be established with other actors in legal and judiciary sector to assure in ensuring that gender related laws are simplified, translated into vernacular language and disseminated and support MoWCA in training law enforcers, VSUs and civil society in gender related laws and rights.

Based on the situation analyses support technically, managerially and financially public and private gender actors to review empowering policies. These examples serve as examples only and should not pre-empt the outcome of the above mentioned situation analyses, at the same time it does not imply that UNFPA can and should take over the entire empowerment agenda, but should have a catalysing role in policy and strategy design: e.g. micro-financing policies in relation to women’ access, improve quality of existing initiatives (e.g. victim/survivor support units; WSC) and/or widen the network of initiatives (e.g. victim support units and workplace initiatives against sexual harassment and GBV/VAW initiatives).

**ISSUES TO BE OBSERVED IN DESIGN AND IMPLEMENTATION**

It is essential to involve comprehensively stakeholders in all steps of a CP cycle, as well as in each project management cycle. This involvement has to go beyond “consultation”, but actual joint decision making. The same applies, although possibly through other modalities, to the target groups of interventions.

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54 This could – just to state examples and not to pre-empt proposals by CSOs - include, however not exclusively: legal literacy of women and men in law related to gender equity and equality; schemes to provide capital for women’s businesses; women’s access to obtain loans/credit at acceptable rates and open bank accounts; training of women on income generating activities, enterprise skills, business development a including management, planning and handling of credit and linking women to micro-financing institutions; inclusion of groups with special needs; children, youth, women and men’s access to prevention and management of GBV and support to victims of GBV and addressing perpetrators; increase female access and participation in adult literacy and decrease of girls dropout rates in school.
UNFPA should assist in the design of complete concepts following a zila specific needs assessment following the above mentioned situation analyses.

Subsequent to the decision which subsectors are prioritised and which objectives are aimed to achieve, elaborate on the nature of implementing partner (governmental body; technical assistance, NGO/civil society) which are best suited for the chosen undertaking. If a combination of the three options is preferred, elaborate on complementarities while staying focused. For example, if Fertility Reduction is the focus, the supply side (service provisions by the public sector) could be supported through a TA package (focused on capacity building and systems building) while the demand side (clients, communities, creation of critical mass) might rather be supported by Civil Society Organisations, whereby a strategy would ensure that the same geographic area is addressed in the right sequence (e.g. ensure that the supply side can adequately respond to an increased demand).

Consequently to the above, the nature of an intervention or objective demand to treat gender as cornerstone than as a crosscutting issue: for example, the increase in the utilisation of FP needs to address the demand side with special emphasis on the gender related power division in decision making power in households, gender based violence, gender based barriers to access health services. This does not mean that the inclusion of “gender” in a project and even more so in a programme design would imply that not only or mainly girls and women would be addressed, but rather the inclusion of boys and men in e.g. FP, ANC and deliveries.

Quality improvements/assurance and monitoring mechanisms need to get a strong weight in the future and should rather be integrated as inbuilt within each project, hereby not be limited to activities for selected sub-objectives or to by separate officers.

UNFPA should rather refrain from the creating parallel systems or interventions outside existing systems, unless these are tested in well defined pilots.

In interventions which foresee pilots and testing, the design and plans of such pilots should ensure, before commencing, that pilots are carried out in mutual agreement with national policy and strategy makers, i.e. to be carried out at the right time and sequence to feed into national decision making in order to offer outcomes which contribute to national think tank and filling knowledge gaps. This implies that the mechanism how a pilot will be used and contribute should be clearly identified from the onset.

Operational research as a tool for quality assurance, programmatic prioritisation and utilisation of information systems can have significant importance and merits to build upon the gained understanding and appreciation by partners, including the linkages of zila and upazila management and services.

**MANAGEMENT ISSUES**

**In respect to the Role of Civil Society Organisations**

As a principle it is always essential to let concerned people or groups decide for themselves what works for them and how. This can be operationalised through CSOs/NGOs which can serve as implementing partners in two aspects:

1. **Call for Proposal**
   
   CSOs can fortify, stimulate and the support ideas, initiatives and also existing intervention by communities and CSOs. This can be achieved through a call for proposal. Interested CSOs could submit technical proposals which elaborate on the approach, methodology and relevant information concerning previous related experience reflecting fertility reduction and gender perspective and work with poor and/or vulnerable groups.

2. **CSOs as implementers of identified intervention**
   
   The RRF will identify which intervention modalities have the most promising effect in contributing to the achievement of the exacted result. These interventions can be outsourced and implemented through CSOs.

**In respect to Sector Ministries/partner institutions, project and programme design, management and steer**

In light of a streamlined concept, even more so to underline the supportive role of UNFPA to MoH&FW and MoWCA and to reduce the administrative and managerial workload and efficiency a drastic reduction
of the numerous PDs is recommended to possible 4 PDs: MoH&FW, MoWCA, the parliament, an umbrella NGO.

Also within the context of the support through technical assistance providing knowledge transfer a split in several small projects is to be discouraged, but rather the modalities and procedures of cooperation and maximising complementarities should be well defined and formulated.

In the context of working with and through NGOs it is suggested to collaborate rather with umbrella or network NGOs, which can subcontract COs, instead of splitting into smaller projects with direct work with high number of COs.

It is more beneficial to cooperate with research and training institutions as subcontractor. There is no real need to organise the cooperation in the mechanisms as a PD.

A strong weight is suggested to be given to formalised and well formulated coordination mechanisms. The TOR of these fora should not be limited to share of information and rather emphasise proactively coordinated and possibly joint planning, implementation and M&E.

- Within UNFPA,
- UNFPA and MoH&FW and MoWCA
- Within MoH&FW and within MoWCA
- MoH&FW, MoWCA, Ministry of Planning and partner Ministries
- UNFPA and UN
- UNFPA and development partners
- UNFPA/Ministries and COs

In projects with a focus on zilas and upazilas the composition and the chair of governing/steering committees should rather be delegated to zilas level in order to allow an effective functioning of these committees. The chair and the secretariat of such committees carry the responsibility of the performance of the committee which in turn is responsible for the performance of the steered projects and programmes.

From zila management view, donor funded and supported projects are more effectively incorporated into a zila level, managerial oversight, when these projects have a zila wide coverage. If funding volume demand restrictions, a content focus is preferred towards a geographic focus. However this recommendation is subject to the management style of the zilas and would need to be re-confirmed during project or programme formulation.

The suggested priorities areas, activities and implementation modalities and approaches underline sustainability from various angles:

- The recommendations contain three pairs of approaches: medium term & immediate effects, central & decentralised approach as well as systems development & individual trainings/education:
  - The weight of the support lies in capacity building, whereby (management) systems- and tools development and institutionalisation and institution building will be accompanied by individual trainings. This paired approach can be expected to have a longer lasting effect.
  - Central ministry capacity building in management systems (financial, human resources, administration, resource management, communication and “soft skills” in management and service delivery/implementation etc) is paired with capacity building at zila/upazila level and implementation. Though activities are phased to allow the zilas to be guided by a strengthened central level while their capacity is addressed, the decentralisation process in decision making and management, can proceed to a degree the zilas and upazilas can absorb and respond to the widened responsibilities.
  - While management and technical capacity on central and zila/upazila level are in the process of being built up, mainstreaming as well as options for empowerment and mitigation are strengthened and supported. This, third, pair can be expected to contribute in the discussions and forming public opinion, attention and credibility in the fertility and gender agenda.
The range of above mentioned capacity building is assumed to create a critical mass among the central and peripheral staff and dynamics between the zilas and the centre, which is probable to carry the agenda forward beyond the funding period.

The elaborated approach might also work towards a future sector wide programming in the MoWCA (as far as ‘gender’ can be viewed as a “sector”) through established technical and managerial systems and supports a more sustained policy, strategy and interventions.

The GoB is signatory to the related conventions and treaties and has emphasised gender related issues in the PSP. The budget allocated to MoWCA might be rather low. However it appears fair to assume that this is not indicating lack of political commitment, but rather be caused by the - in overall - low Government budget. As technical, managerial and communication capacities will be strengthened through UNFPA support, it can be expected that the budget share will increase, based on the already existing political commitment.

Creating much needed widening and/or deepening the knowledge base of socio-cultural aspects and their effect on fertility and well as gender issues will create both, lasting better understanding related issues.

The TOR for technical assistance (TA) need to be explicit and clear that short and long term TA must not carry out tasks on behalf of the receiving institution, but must focus on assisting these institutions in carrying their responsibility.

Impact mitigating and empowering interventions, in particular those carried out by civil society organisations, can partially (services provided in assistance to families in immediate needs due the gender based incidences and problems, e.g. GBV) present dependencies to external funding. This can present a weakness and risk for sustainability and asks for accompanying risk mitigation measures (e.g. creation of moral and financial self help groups) alongside the direct interventions.

Ownership should not be misperceived as not being entitled or not having the responsibility to provide corrective advises, if required, and in turn to accept these technical corrections by the advise receiving end. Mutuality and mutual respect have to be ensured during this technical exchange.

**UNFPA Internal**

The recommendations imply that major adjustments are required for and within UNFPA. For this purpose a two-staged transition period could be applied:

- the additional, last year of the 7th CP cost – extension for UNFPA focussing on in-house capacity increase, organisational and managerial revisions and design of exist strategies for interventions dependent on UNFPA but to be continued without direct UNFPA’s involvement;
- the 8th CP can be phased with the first phase of two years being part of the transition to implement the exit strategies, complete situation analyses, lobby and advocate for political commitment, plans, budget allocation etc while the new interventions can already commence.

The UNFPA office is planning to undergo a re-profiling of the office positions and the organogram. This is essential and the ET would confirm the need and appropriateness of this plan. Prior to the re-profiling it is suggested to conduct by external experts

- A thorough organisational assessment and functional diagnose
- Complete the 8th CP – it is more effective to organise an entity around the envisioned “product” than the “product” around the organisation.

The UNFPA office organogram, working and communication style needs to reflect the recommendations and direction UNFPA is suggesting to the public sector (“do yourself what you preach”). This includes:

- The current strong hierarchical working style needs to change drastically to a supportive mindset.
- In particular the sub-offices need to be adequately posted, i.e. vacancies urgently filled and put rather in a lead role and this lead role needs to be supported. It is recommended that the chiefs of the sub-offices are part of the senior management team.
• NPPPs are not to be considered as secondary, less recognised UNFPA staff. The success of the 8th CP will be largely dependent on the success of the NPPPs. The role of the NPPPs requires an overall revision and the TOR matched with actual needs and management systems strictly adjusted. The NPPPs, as seconded staff, should rather report to the ministries, based on a Memorandum of Understanding between the MoWCA/MoH&FW and UNFPA. It is appropriate that the NPPPs remain in their respective ministries, but with revised, clear, explicit and with the ministries mutually agreed TOR which focus on policy, strategy development and institutional development.

• Both of the above need to be supported and facilitated. They are not to be considered executors of office based decisions, but rather should be in the lead position in all stages of the interventions and project management cycle.

Horizontally, the communication and cooperation style has to reflect a strong team-spirit with the preparedness and willingness for a problem solving spirit and not territorial thinking and acting.

Monitoring has to be an integrated part of all staff responsible for project/programme management. Financial analyses should be routine and carried out regularly.

In overall, the capacity of the UNFPA office requires to be elevated in its strategic, technical, supportive and teamwork capacities. If the UNFPA staff requires technical support to carry out their TORs, additional training and even more so coaching should be provided, based on individual needs assessment. The regional UNFPA office might be in the position to contribute to this process. Additional TA support to the office could also be considered. The planned re-profiling will also contribute in this direction.

The current tens spirit in the office will certainly improve after the planned re-organisation of the office, provided each staff member is motivated to invest with team spirit.
5 ANNEXES

5.1 ANNEX 1: CRITERIA MATRIX

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5.3 ANNEX 3: YEAR-WISE BUDGET VS EXPENDITURE STATEMENT

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5.6 ANNEX 6: UNFPA BANGLADESH: ORGANOGRAM (EFFECTIVE 01 JANUARY 2010)

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Terms of Reference
For the Evaluation of
The 7th Country Programme of UNFPA Bangladesh

1. Introduction and Background

The United Nations Population Fund (UNFPA) has been working in partnership with the Government of the People's Republic of Bangladesh since 1974 through technical advisory services and financial support. So far, UNFPA has completed six country programme cycles, while it is currently carrying out its seventh country programme (2006-2010). At the request of the Government, the country programme has been extended by an additional year, and will now be completed by 31 December 2011.

Bangladesh has made significant progress in pursuing many of the goals of the ICPD Programme of Action and the Millennium Development Goals (MDGs). The national development plans, i.e. the (Poverty Reduction Strategy paper) PRSP, also focused on the general improvements in the quality of life of the Bangladeshi people, and reductions in the number of poor people in the country. However, progress has been uneven, and socio-economic, geographical and gender inequalities have been widened. Especially, inequalities in access to quality reproductive health services and disparities in health outcomes and gender inequalities in many areas persist in the country.

The 7th country programme of assistance (7CP) of UNFPA is built on the experiences of earlier country programmes and reflects the ICPD agenda and the Beijing Plan of Action, the priorities of the common country assessment/United Nations Development Assistance Framework (CCA/UNDAF), the UNFPA multi-year funding framework (MYFF, 2004-2007) and UNFPA's strategic plan (2008-2011). The programme has also taken into account the MDGs and PRSP targets. The programme emphasises capacity development, service delivery, with particular focus on the poor and vulnerable populations, and gender equality and the empowerment of women, with special emphasis on gender-based violence (GBV). This programme also supports the health-sector SWAp (Health, Nutrition and Population Sector Programme – HNPSP) through parallel funding as well as pool funding with a small proportion of funds placed in the pool. The programme is nationally executed with Government, in close partnership with other United Nations agencies, NGOs and the private sector.

5.13.1.1.1.1.1 The programme is organized around three mutually re-enforcing programme components: i) Reproductive Health (RH), ii) Gender, and iii) Population and Development (P&D).

The results and resource framework (RRF) of the 7th CP clearly identified the outcomes and outputs with relevant indicators and resource requirements.
5.13.1.1.1.1.1.2

5.13.1.1.1.1.1.3 The Reproductive Health component has two outcomes, i.e. (1) Population and reproductive health strategies (the PRSP, MDG report, the SWAp and the population policy) are effectively translated into programmes, especially for the poor and vulnerable; (2) Young people are given information and services, and are empowered to protect themselves, especially against STIs and HIV/AIDS, with four corresponding outputs that contribute to these outcomes. The component mainly focuses on capacity development in the RH sector with special attention to safe motherhood (particularly emergency obstetric care (EmOC) and safe home delivery by community-based skilled birth attendants (C-SBAs)) and maternal morbidity (fistula, cervical and breast cancer), family planning, Reproductive Health Commodity Security (RHCS), adolescent and youth reproductive health, STI and HIV/AIDS prevention.

5.13.1.1.1.1.1.4 The Gender component has one outcome, i.e. Women and girls are supported and empowered to make decisions about their reproductive health, with one output that contributes to this outcome. The component is focusing on equity and equality issues through women’s empowerment, prevention and response to GBV, raising awareness on gender issues and development of male coalitions for supporting women’s rights.

5.13.1.1.1.1.1.5 The Population and Development component has one outcome, i.e. a policy environment that promotes reproductive health and rights is created, with two outputs that contribute to this outcome. The component is emphasising the utilization of gender and poverty disaggregated data for development planning and poverty reduction. Another emphasis of this component is the development of digital mouza maps that are being used for the forthcoming population and housing census 2011. Moreover, the programme supports advocacy activities on population, gender, and reproductive health and rights at national and sub-national levels, including through South-South cooperation.
5.13.1.1.1.1.1.6 For the first time in its country programme, UNFPA, in consultation with the Ministry of Health and Family Welfare (MOHFW) selected two underserved and low performing districts (i.e. Cox’s Bazar and Sylhet). The districts were selected from two low performing divisions (Chittagong and Sylhet) based on the performance of some RH indicators such as

5.13.1.1.1.1.7 MMR, IMR, CPR, percentage of women received ANC, Mean age of first marriage and female literacy rate. Districts were planned for comprehensive programme interventions under the 7CP, while many of the interventions are national in scope, e.g., advocacy, contraceptive security and the SWAp. The district level programme interventions are being coordinated through two field/district offices.

5.13.1.1.1.1.1.8 Sixteen implementing partners from twelve ministries, one NGO and an autonomous body (Bangladesh Garments Manufacturers and Exporters association – BGMEA), are carrying out the activities to achieve the above outputs and contributing to the outcomes. The Economic Relations Division (ERD) of the Ministry of Finance is working as the overall coordinating agency for the 7th County programme.

In addition to the country programmes, UNFPA Bangladesh had three joint programme such as Demand based RH commodity project (funded by CIDA, recently concluded), Accelerating the reduction of maternal and neonatal mortality and morbidity (funded by DFID/EU), and Reduction of violence against women (MDG Spain fund). All these projects have contributed to the country programme.

2. Current status

The 7th Country Programme is currently on its fifth year through the planned implementation period. However, it has been extended by one additional year in order to harmonise the programme with the UNDAF, other UN agencies country programmes, and the Joint Cooperation Strategy (JCS). During the last years, the Country Programme has focused mainly on strengthening technical and institutional capacities of government counterparts. Capacity development activities have been promoted, including development of protocols and guidelines and training materials, conducting training and orientations in relevant reproductive health and population and development and gender issues, and supporting knowledge-sharing activities.

Monitoring and accountability mechanisms have been established: Baseline information for country programme indicators was collected through baseline study and an end line survey is being conducted in the two pilot districts to
provide information on the current status of the indicators and progress compared with baseline; Monitoring of implementation status of planned activities was done quarterly; two district offices in Sylhet and Cox Bazar were established to coordinate and monitor the targeted interventions in the respective districts and a number of relevant research studies were conducted during the 7CP.

3. Purpose of the Evaluation

According to the UNFPA Evaluation policy, an end of programme evaluation is mandatory and should be carried out in the penultimate year of the country programme. The evaluation will identify and document the achievements of the country programme as well as challenges encountered and the lessons learned and will contribute to the planning of the next cycle of UNDAF and the Country programme.

The current 7th CP (7CP) was developed based on the earlier Multi-year Funding Framework 2004-2007 (MYFF) and started its implementation from January 2006. In July of 2007, UNFPA issued its corporate strategic plan for the period 2008-2011 "Strategic plan 2008-2011: Accelerating progress and national ownership of the ICPD Programme of Action". The plan defines 3 goals, 13 outcomes and indicators in the 3 focus areas of population and development, reproductive health and rights, and gender equality. Since the strategic plan serves as the centrepiece for programming in the coming years, the final CP evaluation will be done in line with the strategic plan.

The evaluation exercise will assess the UNFPA’s programme of assistance as it relates to the country's situation and population goals as well as to goals set forth at the ICPD. One important function of the evaluation is to assess the country's needs as reflected in the country programme. This will be done through a thorough assessment of the programmatic strategies using the UN standard criteria of evaluation (relevance, effectiveness, efficiency, impact, sustainability and management system) in relation to the expected outputs and outcomes. The evaluation will lead to recommendations on necessary measures to overcome problems identified and will serve as the start of the preparations for the next UNDAF and 8th CP. In that regard, the findings of the evaluation will be primarily used by UNFPA and the government and other stakeholders.

4.1 General objective of the Evaluation

The general objective of the evaluation is to assess the achievement of the programme at the end of the programme cycle in terms of planned outcomes, outputs and strategies, the factors that affected or facilitated the achievement, and to compile lessons learned so as to contribute to the development of the next country programme cycle.

4.2 Specific Objectives
The Evaluation will be retrospective as well as forward looking and therefore will:

vii) Assess the current status of achievements (i.e., results and impact) of the 7th UNFPA country programme based on established outputs and outcomes through:
- Comparing the planned activities, outputs, and outcomes with actual results
- Comparing and analysing the baseline and end-line survey data/information from the two districts, as well as other studies and evaluations conducted during the current country programme cycle
- Collecting additional information from the partners
- Determine the sustainability and impact of the programme achievements

viii) Assess the relevance and effectiveness of the technical approach (e.g., women support centre in responding to gender based violence) as well as overarching country programme strategies (i.e., capacity development initiatives (training, TA support, study tours, etc.); BCC / advocacy strategies (material development, policy dialogues, influence on the sector programme, etc.); number of IPs and district based approach) toward achieving the CP outcomes and outputs.

ix) Assess the effectiveness and efficiency of the programme management, implementation, coordination and linkages between three main programme areas, partnership and monitoring.

x) Assess the efficiency of the current programme approaches including so many IPs for implementation of the programme and coordination issues.

xi) Based on the above analysis, identify facilitating and constraining factors affecting programme performance (including management issues) and document the best practices and key lessons learned from the 7th CP implementation.

xii) Provide key recommendations/directions for the 8th Country programme in the area of population and development, RH, and gender, including:
- Strategic areas and issues of potential UNFPA contribution to the new programming in 2012-2016 in line with the national priorities as well as in light of accelerating the progress toward MDGs and number of partnerships.
- recommendations for UNDAF and preferred programme management modalities based on the lessons learned

4.3 Key evaluation questions
The evaluation will focus on the specific objectives and will try to answer the specific questions to meet the objectives. As per the above objectives, the specific questions to be answered are:
What the current status of achievements of the stated outputs and outcomes as mentioned in the 7th CP RRF through the planned activities?
What progress towards the outcomes has been made?
To what extent have the planned outputs and assistance contributed to achieving the outcomes?
To what extent are the technical approaches e.g. Women support Centre (WSC) and overreaching strategies/ capacity development strategies (e.g. training, TA support, study tours, district based approaches) are relevant and effective in achieving the outputs and outcomes.
What is the effectiveness of the IPs in contributing to the outputs and outcomes? Are they well aligned and efficient to contribute to the outcomes?
What is the efficiency of having so many partners? Are they appropriately and adequately contributed to the Cp outcomes?
What are the constraints and facilitating factors that affect achievement of the intended results including the effectiveness and ineffectiveness of the intended results?
How and to what extent has the programme management, implementation, coordination, linkages, partnership and monitoring and evaluation contributed to the effectiveness of the programme?
How and to what extent has the 7th country programme leveraged the multi-bilateral projects funded by other donors and the support to HNPSP through pool funding to maximize the effectiveness of the programme? What is the lessons learned from this?
What are the key lessons learned from the 7th country programme design and implementation?
What are the key recommendations that should be addressed in the design and implementation of the 8th country programme? (including support to the new health SwAP, and response to the emerging issues such as climate change, urbanisation, disaster management, etc.)
What is linkage between the ongoing MNH programme and the CP and SWAp? How are the lessons learned from the joint programme used for strengthening the CP as well as the HNPSP. What are the lessons learned from Joint programmes - partnership etc.?

The evaluation questions will be discussed with the partners and consultants during the initial meeting. According to the suggestions of the meeting, the questions may be revised.

5. Scope of the Evaluation

A team of evaluators will be involved to cover all the areas of the country programme. It is planned that an international consultant will act as Team Leader and will guide the evaluation process. Three evaluators will be recruited locally to collect and analyse information and evaluate the three UNFPA programme Component i.e. RH, Gender and P&D as per guidance and support from the evaluation advisor/Team Leader. The international consultant/Team Leader is expected to make two visits for the evaluation. i.e. first visit will be for first two weeks during that time/he/she will with the team, attend the initial meeting, prepare inception report, review necessary papers and may have some consultation with the stakeholders/field visits and guide the evaluation team. The local member
of the team will continue to work on the evaluation including field visits, data collections, necessary interviewed etc as per guidance of the Team leader. The second visit will be made to Dhaka at the end forth week of evaluation, when that will complete the draft report and make a presentation of the draft report to the stake holsters.

The evaluation will be done for the actual duration of the current country programme only (2006-2010) but it would be forward looking and will contribute to the design of the forthcoming country programme.

In terms of the geographical spread, the evaluation will be national and would focus on national programme strategies. However, it will also look into the two pilot districts on particular strategies and achievements, using the results from the baseline and end line surveys and other inputs such as training and advocacy activities.

The evaluation will also focus on the three major UNFPA country programme components which were funded from the UNFPA core resources. Multi-bilateral projects and projects funded by other donors during the country programme are beyond the scope of the present evaluation; however, the evaluation should comment on how the country programme has taken advantage of those stand-alone projects to maximise the overall programme performance. Similarly, while the achievement of the health, nutrition, and population sector programme (HNPSP) which UNFPA supports through the pool funding under the 7th CP is also beyond the scope of the present evaluation, the evaluation should examine how UNFPA has leveraged this investment and recommend the size and quality of the investment to the next sector programme under the 8th CP from both aid-effectiveness and programme effectiveness points of view.

The evaluation may also comment on some of the emerging issues that might not have been addressed or inadequately addressed during the 7th CP but have potential to be addressed through the 8th CP, such as, climatic changes, urbanisation, refugee population, emergency/disaster preparedness and humanitarian response during disasters. Evaluators may review relevant literature on these and may also interview some the stakeholders outside UNFPA's present IPs.

The evaluation will strictly follow the UN standards and principles of evaluation and follow the evaluation criteria such as relevance, effectiveness, efficiency, impact, sustainability, management systems (human resources, financial resources, systems etc) for each component and strategy mentioned in the objectives.

It may be mentioned that UNFPA country office has already organised separate evaluations for some of the country programme approaches e.g. Community based Skilled Birth Attendance (CSBA), Peer Approach etc. The findings of these studies may be used as appropriate to complete the CP evaluation.

6. Management and Methodology

The Evaluation exercise will be independently done by the evaluator, however, they supported and coordinated by the Government Coordinating Agency, i.e. ERD (Economic Relations Division) and UNFPA. The UNFPA Senior Programme Officer (M&E) will serve as the evaluation manager and as the primary liaison between the team and UNFPA, coordinate UNFPA's internal review processes, and provide written approval of all deliverables after consultation with the UNFPA Representative and Deputy Representative. All events of the evaluation will be
organised in consultation with the Government. UNFPA Bangladesh will recruit one national technical expert/evaluator for each Programme Component (RH, P&D and Gender).

The UNFPA Asia and the Pacific Regional Office (APRO) in Bangkok, Thailand, will provide inputs in finalizing the TOR. The UNFPA Bangladesh country office will seek support from the APRO for assisting in selecting an evaluation expert/Team Leader for overall guidance and technical support throughout the evaluation process.

The initial meeting will be organised as soon as the evaluators are available, to discuss and finalise the TOR and work plan in consultation with the UNFPA country office and ERD. All the implementing partners and stakeholders of UNFPA 7CP will be invited to attend the meeting. The meeting will also discuss the methodology, agree and finalise the evaluation methodology.

**Methodology:**

The evaluation will be mainly based on the Results and Resource Framework but will specifically focus on the objectives as outlined in this TOR. The methodology would be directly driven from the specific objectives. An evaluation methodology will be developed by the evaluators based on the evaluation objectives and questions.

The evaluation will employ an appropriate mix of quantitative and qualitative methods based on the evaluations objectives/questions. Primary data collected from the field levels (from two pilot districts) during the baseline and end-line survey will be used for evaluation. Evaluators are encouraged to use data from other published sources or research/studies for triangulation and validation of the information. Evaluators may collect qualitative information through focus group discussions, community meetings and interviews with the stakeholders and Implementing Partners (IPs) etc. and information may be used for interpretation as well as to justify and validate the achievements.

The consultants will conduct field visits as required and these should be planned in advance (after the initial planning meeting and should be incorporated in the inception report) The consultants will work in close collaboration with the country office (CO) staff and GOB counterparts. They will collect information independently and conduct interviews, as necessary, with IPs and stakeholders as required. The UNFPA CO staff will also assist the consultants in collecting information, organizing field visits and making appointments for interviews. The evaluation will be done in a four to five weeks period.

The consultants will be responsible to collect and review information under the guidance of the Team Leader who will coordinate the activities of other consultants, maintain liaison with UNFPA, and prepare consolidated final evaluation report that
integrates critical issues that emerge from the inputs of each component consultant.

Tentatively in the last week of December an evaluation meeting will be planned during which main findings, conclusions and recommendations of the evaluation will be discussed among the Government representatives from relevant ministries, implementing partners, NGOs, donors and other UN agencies. The draft report will be also submitted to UNFPA and ERD, and ERD will seek comments from relevant ministries. The evaluation team leader will finalize the report taking into account the comments from the ministries/divisions/agencies. This may be done after some time of presentation and submission of draft report.

7. Documentation

As mentioned earlier, the CP Evaluators will review necessary documents related to country programme implementations, including:

i) UNFPA 7 Country programme (2006-2010) document (CPD)
iii) UNFPA Strategic plan (2008-2011)
v) Standard progress report for the last four years
vi) Field monitoring visit reports by programme staff
vii) 7th CP baseline survey report
viii) 7th CP end-line survey report
ix) Studies conducted during last three years.
x) Mid-term review report
xi) Report on the evaluation/ studies on different components
xii) Other relevant reports and documents
xiii) Flood response report
xiv) Delivery in emergency situation (Study report)
xv) The annual reports of the joint programme.
xvi)

8. Deliverables

Within 7 days of award of contract, the evaluation team shall submit an electronic copy of a draft inception report to UNFPA’s evaluation manager. The inception report provides an opportunity for UNFPA and the evaluation team to ensure that their interpretations of the TOR are mutually consistent. The manager will review and approve the report, which will serve as an agreement between UNFPA and the evaluation team about how the evaluation will be conducted. This inception report shall:

- Explain the evaluation team’s understanding of what is being evaluated and why;
Describe the team's strategy for ensuring the evaluation's utility and applicability to the needs of UNFPA and those of key stakeholders;*  
Describe the evaluation team's plans to engage and involve these stakeholders in the design (e.g., questions, objectives, methods, data-collection instruments), data collection, data analysis, and development of recommendations;*  
Explain how the evaluation questions will be addressed with respect to all evaluative criteria indicated above by way of proposed methods, evaluation designs, sampling plans, proposed sources of data, and data-collection procedures;*  
Note: The evaluation team is encouraged to suggest refinements to the TOR and to propose creative or cost- or time-saving approaches to the evaluation and explain their anticipated value.  
For each of the evaluative criteria, describe the measurable performance indicators or standards of performance that will be used to assess progress towards the attainment of results, including outcomes;*  
Discuss (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluation team to attribute results observed to UNFPA's efforts especially when there is no consideration of a valid counterfactual and (b) what will be done to minimize the possible biases and effects of these limitations;*  
Explain the team's procedures for ensuring quality control for all deliverables;  
Explain the team's procedures to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during and after discussion of sensitive issues with beneficiaries or members of the public;*  
Explain how the evaluation will reflect attention to and mainstreaming of gender concerns and identify the member of the evaluation team who will be responsible for doing so;*  
Indicate familiarity with and agreement to adhere to (a) the requirements of the Standards for Evaluation in the UN System, especially standards 4.1 through 4.18 and (b) UNFPA's Evaluation Quality Standards, which will be provided to the evaluation team; and,  
Provide a proposed schedule of tasks, activities, and deliverables consistent with this TOR.

The evaluation team may be asked to make an oral presentation of the inception report to UNFPA and its stakeholders. UNFPA's evaluation manager will provide written comments on the inception report to the team within two days of the report's submission or completion of the oral presentation, whichever comes later. UNFPA reserves the right to modify the TOR in response to the inception report.

The evaluation team shall submit an electronic copy of a draft evaluation report to UNFPA's evaluation manager no later than end of forth week from the start of evaluation. The draft report should be thoroughly copy edited to ensure that comments from the UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum.

55 Note: Items marked with an asterisk should also be discussed in the evaluation report.
After UNFPA’s and stakeholders’ review of the draft report, the evaluation manager will provide written comments to the evaluation team. Based on these comments, the team shall correct all factual errors and inaccuracies and make changes related to the report’s structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The team will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the evaluation team will submit a revised draft evaluation report, which may lead to further comments from UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report, the evaluation team can then submit hard and soft copies of the final report pending UNFPA’s approval. The report should follow the outline attached in Annex -2.
Evaluation should maintain the ethical standard of the UNEG throughout the evaluation process.
### Tentative Schedule of the UNFPA 7th CP Evaluation Activities (to be further revised)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Tasks/Activities</th>
<th>Tentative dates (December 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Share TOR with ERD and agree on timeframe for CP evaluation</td>
<td>UNFPA Representative, Deputy Rep.</td>
</tr>
<tr>
<td>2</td>
<td>Finalise selection of national consultants/Evaluator</td>
<td>UNFPA Representative, Deputy Rep.</td>
</tr>
<tr>
<td>3</td>
<td>Request APRO for comments on TOR and appoint consultant and team leader/Int’l consultant.</td>
<td>UNFPA Representative, Deputy Rep.</td>
</tr>
<tr>
<td>4</td>
<td>Initial meeting with the evaluators and stakeholders.</td>
<td>UNFPA Representative, Deputy Rep., UNFPA Programme staff, GOB/ERD</td>
</tr>
<tr>
<td></td>
<td>Finalise TOR, methodology and work plans for the evaluation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluators to submit inception report detailing methodology and other issues as per TOR.</td>
<td>Evaluators/Consultants, UNFPA Programme staff, IPs and stakeholders.</td>
</tr>
<tr>
<td>5</td>
<td>Review relevant documents related to CP7, Baseline and endline survey results etc.</td>
<td>Evaluators (programme staff will provide information as necessary)</td>
</tr>
<tr>
<td>6</td>
<td>Meeting with programme staff, GOB IPs and stakeholders (will be further elaborated) and collect information as appropriate.</td>
<td>Evaluators/GOB, UNFPA programme IPs and stakeholders</td>
</tr>
<tr>
<td>7</td>
<td>Field visits by evaluators with UNFPA/IP staff (will be further elaborated in consultation with the IPs)</td>
<td>Evaluators/GOB, UNFPA programme IPs and stakeholders</td>
</tr>
<tr>
<td>8</td>
<td>Analyse data and preparation of draft report by component and consolidated report</td>
<td>Evaluators</td>
</tr>
<tr>
<td>9</td>
<td>In house presentation of draft report and discussion</td>
<td>Evaluators, GOB to join the discussion</td>
</tr>
<tr>
<td>No.</td>
<td>Activity</td>
<td>Implementer</td>
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<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
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<tr>
<td>10</td>
<td>Incorporate comments and finalise draft report.</td>
<td>Evaluators</td>
</tr>
<tr>
<td>11</td>
<td>Final Evaluation meeting and sharing draft report with stakeholders.</td>
<td>Evaluators/UNFPA/IPs, GOB/ERD, Stakeholders</td>
</tr>
<tr>
<td>12</td>
<td>Submit final report to UNFPA Representative/ERD after incorporating the comments on the final draft. This may be done after the conclusion of the final evaluation meeting</td>
<td>Evaluators</td>
</tr>
</tbody>
</table>
Profile of the Consultants

As mentioned earlier, a team of four consultants will work for the evaluation of the UNFPA Bangladesh 7th country programme. The team leader will be identified by APRO/Bangkok. Other consultants will be selected by UNFPA Bangladesh in consultation with APRO and Government coordinating agency.

Expected profile of the consultant is given below:

A. Team Leader

- Senior consultant or expert with at least fifteen years of experience in evaluation work both for national and international organizations.
- Advanced degree in population/Health /Social sciences with extensive experience on evaluations.
- Adequate understanding on RH/Population and Gender issues including understanding on UNFPA Strategic plan, ICPD and MDGs.
- Adequate understanding on Bangladesh health system and HNPSP is plus.
- Excellent oral and written English
- Excellent analytical skills

B. Consultant/Evaluator for Reproductive Health Component

- Advance/Post Graduate degree in Public Health
- At least 10 years experiences in reproductive health.
- Knowledgeable in RH & Population issues; HNPSP, RH & Population policies in Bangladesh; and Bangladesh Health System
- Experienced in evaluation, consultancy work and research undertakings
- Excellent oral and written English
- Excellent analytical skills
- Excellent interpersonal skills
- Good computer skills
- Excellent in team work

C. Consultant/Evaluator for Population and Development

- Advance/Post Graduate degree in Demography, population, statistics, public health and other related social development fields or relevant discipline.
- At least 10 years experiences in consultancy work in national and international organizations in the areas of demography/ population
- Knowledgeable in Population and Development Strategies in Bangladesh; RH, HNPSP, Population policies in Bangladesh; and Bangladesh Health System including population and poverty issues, national data collection like surveys and censuses, national statistical systems especially local
valuable resources, such as statistical databases, emerging population and development issues (climate change, urbanization, etc.), and policy research in general:

- Experienced in evaluation, consultancy work and research undertakings
- Excellent oral and written English
- Excellent analytical skills
- Excellent interpersonal skills
- Good computer skills
- Excellent in team work

A. Consultant/evaluator for Gender

- Advanced degree in Gender, Development, other social science, Health, or other related fields
- Experienced in evaluation, consultancy work and research undertakings
- Demonstrated experience in project/programme management at national/international level.
- A minimum of 10 years working experience in Gender equity and equality, Women’s empowerment and Gender Based Violence issues is required.
- Excellent oral and written English
- Excellent analytical skills
- Excellent interpersonal skills
- Good computer skills
- Excellent in team work

No member of the evaluation team shall have had any prior involvement with the design, implementation, supervision, or financing of the activities to be evaluated. UNFPA’s evaluation manager shall be informed of any situation or circumstance that may be perceived as a conflict of interest for any member of the evaluation team.

The evaluation team will be remunerated according to the following schedule: (a) 30 percent of payment upon completion of a satisfactory inception report; (b) 20 percent upon successful completion of field work; and, (c) 50 percent upon submission of a satisfactory final report and accepted by UNFPA.
Annex 2:
Outline of the Evaluation Report

5.13.1.1.1.1.8.1

5.13.1.1.1.1.8.2 Title page
  - Name of project, programme or subject being evaluated
  - Name of the organization(s) to which the report is submitted
  - Names and affiliations of the evaluators
  - Date

5.13.1.2 Table of Contents

5.13.1.3 Acknowledgements
  - Identify those who contributed to the evaluation

5.13.1.4 List of abbreviations and acronyms

5.13.1.5 Executive summary
  - A self-contained paper of 1-3 pages, summarizing essential information on the subject being evaluated, the purpose and objectives of the evaluation, methods applied and major limitations, the most important findings, conclusions and recommendations in priority order.

5.13.1.6 Introduction (3-5 pages)
  - Describe the project/programme/theme being evaluated, including the problems being addressed by the interventions.
  - Summarize the evaluation purpose, objectives, and key questions.
  - Explain the rationale for selection/non selection of evaluation criteria.
  - Describe the methodology employed to conduct the evaluation.
  - Detail who was involved in conducting the evaluation and what were their roles.
  - Describe the structure of the evaluation report.

5.13.2 Findings and Conclusions (may be divided to 3-4 chapters, total 20 pages)
  - State findings based on the evidence derived from the information collected. To the extent possible measure achievement of results in quantitative and qualitative terms, and analyze the linkages between inputs, activities, outputs, outcomes and, if possible, impact.
  - Discuss the relative contributions of stakeholders to achievement of results.
  - Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the evaluation objectives and provide answers to the evaluation questions.

5.13.2.1

5.13.2.2 Lessons learned (3-5 pages)
  - Based on the evaluation findings and drawing from the evaluator(s)' overall experience in other contexts, provide lessons learned that may be applicable in other situations as well. Include both positive and negative lessons.
5.13.2.3 **Recommendations (2-3 pages)**

- Formulate relevant, specific and realistic recommendations that are based on the evidence gathered, conclusions made and lessons learned, and discuss their anticipated implications.
- List proposals for action to be taken (short- and long-term) by the person(s), unit or organization responsible for follow-up in priority order.
- Provide suggested time lines and cost estimates (where relevant) for implementation.

5.13.2.4 **Annexes**

- Attach evaluation terms of reference.
- List persons interviewed, sites visited.
- List documents reviewed (reports, publications).
- Attach data collection instruments (e.g., copies of questionnaires, surveys, etc.); web links.

27 November 2010