Annex: (A to H) Additional Supporting Data and Information

Annexes A-H attached here provide additional information (not obligatory by CPE) collected by the evaluation team to support the findings of the CPE that can be useful to the Country office as well other interested parties and as input for future CP evaluations.

Annexes A to D provide additional information on performance data and other achievements under SRHR (A1-A5), A&Y (B1), GE (C1) and PD (D1-D3) outcome areas)

- **Annex A-1 to A-5 (SRHR)**
- **Annex B-1 (A&Y)**
- **Annex C-1 (GEWE)**
- **Annex D-1 to D-3 (PD)**

Annex E (Additional information on Relevance criteria –under each Outcome Area SRHR, A&Y, GE and PD)

Annex F (1-4) TOC (Programme Logic diagrams/Intervention Logic)

Annex G (UNFPA Coordination Role)

Annex H (1-2) Stakeholder Map

Annexes 1-5 Separate folder that contain the obligatory information as per CPE guidelines

Annex 1: TOR

Annex 2: List of Persons Met

Annex 3: List of Document Consulted

Annex 4: Evaluation Matrices

Annex 5: data Collection Tools

Annex A- 1: Government SRHR related Policies and Plans

Goals of the GOB seventh five-year plan, 2016-2020 include 80 percent contraceptive prevalence rate. In terms of maternal and child health, the plan identifies the need to enhance deliveries by skilled birth attendants and the enhancement of ante-natal care. The plan pays attention to the different needs of health services in rural and urban areas, the need for gender friendly health services and the adaptation of services to the specific requirements of tribal areas and people with disabilities. [1]

The Eclampsia and Postpartum Hemorrhage (PPH) Action Plan of 2018, identifies postpartum hemorrhage and eclampsia as the two main causes for maternal deaths in Bangladesh and provides measures to address both these causes. The aim of the plan is to accelerate the reduction of maternal mortality and morbidity caused by eclampsia and PPH by 2022 through improved access to evidence-based maternal health care and emergency obstetric care.[2] UNFPA's programme is aligned with the action plan, in terms of its support to midwifery as a profession, which includes the objective of enhancing the capacities to deal with cases of eclampsia and PPH through facility based delivery, supported by midwives.

The fistula strategy, includes the goal of zero incidence of obstetric fistula, to treat all genital fistula on a road map to a fistula-free Bangladesh by 2030. It, moreover, covers ways to translate the directions of the strategy into the operation plans of MOHFW. The strategy focuses on six key strategic directions, including prevention, awareness, treatment, quality of surgery, rehabilitation/reintegration and evidence generation through research. The strategy highlights the role of other ministries, including Ministry of Social Welfare, Ministry of Women Affairs and Department of Youth Development, to play a role in restoring the dignity of fistula survivors through rehabilitation and reintegration in society.[3] The UNFPA programme support, with its focus on identification, treatment, rehabilitation and reintegration, aligns closely with the strategy.

The Cervical cancer strategy provides broad guidelines for the strengthening of the National Cervical Cancer Control Programme, through the implementation of population- based cervical cancer screening and treatment through the public health delivery system and the introduction of vaccination of adolescent girls against the Human Papillomavirus, using the expanded programme on immunization. For the implementation of the strategy, adequate human resources are to be developed and deployed for service delivery concerned, including appropriate referral and treatment facilities are to be made available.[4] While the UNFPA support focuses on support to cervical cancer screening and treatment, the issue of vaccination is supported by WHO.

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

[2] Directorate General of Health Services, Directorate General of Family Planning and Directorate General of Nursing and Midwifery, Eclampsia and PPH Action Plan in Bangladesh 2017-2022, Dhaka, 2018

[3] Ministry of Health and Family Welfare, government of the People's Republic of Bangladesh, National Strategy for Obstetric Fistula, 2017-2022, Dhaka, September 2018.

[4] Directorate General of Health Services, Health Services Division, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, National Strategy for Cervical Cancer Prevention and Control Bangladesh (2017-2022), Dhaka, 2017.

The National Adolescent Health Strategy has identified four priority thematic areas of intervention: adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition and mental health of adolescents. Social and behavioral change communication and health systems strengthening are included as cross-cutting issues, which are deemed required for the effective implementation of the strategy.[5]

Annex A-2: Details on MNH programme of the SRHR Outcome Area

In order to develop the capacity of midwives, rather than for UFNPA to train midwives, the programme supported the development of the education system required for the training and posting of midwives. UNFPA worked with DGNM and Dalarna and Auckland Universities to enhance the capacities of the Nursery Training Colleges, in the process renamed to Nursery and Midwifery Training Colleges. In addition to the three year diploma training for midwifes[6], a curriculum[7] for a Bachelor's of Science in Midwifery was developed and was about to be introduced in order to provide a career path for midwives. Moreover, a web based Master's degree programme in sexual and reproductive health and rights and midwifery science, was developed, which made use of simulation teaching, for government employed midwifery faculty, who were trained to run Midwifery Led Care in Nursing Colleges, in this way enhancing midwifery education. A faculty development plan was prepared, which included a PhD component, in cooperation with the University of Dhaka, which has added a research component, enhancing in this way the evidence-based approach that underpins the setup of the midwife led continuum of care. The first batch of registered midwives graduated in December 2015.[8] 37 district and medical college hospitals were used as primary clinical sites for midwifery education.

UNFPA worked with the NGO UCEP to ensure that all learning facilities, including library, computer lab and skills lab were accessible to students of the registered midwifery course, also after the class hours of 8.00 AM to 2.00 PM. In interviews with recently posted midwives it appeared that in practice this objective could not yet be fully realized.

A mentorship programme was set up to enhance capacities of midwifery students and to support newly deployed midwives in carrying out their profession. This was done in partnership with Save the Children International (SCI) in 60 upazila health complexes and with the Obstetric and Gynecological Society of Bangladesh (OGSB). The mentorship programme was a response to the limitations of the training of the registered midwives as well as to the difficulty for them to actually get to do the work for which they were trained within the health facility in which they were posted. The mentors being doctors themselves, had the right position and knowledge to support the midwives in this respect and to

[5] Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, National Strategy for Adolescent Health 2017-2030, Dhaka, December 2016.

[6] In interviews with registered midwives some limitations of the training were identified, including the curriculum as well as the test are in English (though the training itself is in Bangla) with student capacities in English often limited and students often not reaching the minimum amount of practicing 40 births at clinical sites during their training.

[7] The quality of the curriculum was assessed by the University of Auckland, which found it to be 'world class' and in line with the international ICM standards. Source: McAra Couper, Dr Judith and Dr Joan Skinner, An Assessment of Midwifery Education and a Framework for Midwifery Teacher Development in Bangladesh, New Zealand, January 2017.

[8] The registered midwives added to the existing certified midwives, which concerns nurses that followed a 6 months training course to become a midwife in the previous UNFPA programme cycle.

address any gaps in terms of the training of the midwives and the application of their learning in practice. This proved a very useful move and the mentoring programme proved a critical aspect of the programme in this respect.

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

The first two batches of registered midwives were posted by DGNM so far. A total of 1,149 registered midwives have been posted in rural areas of high need, in particular in Upazila Health complexes and to a lesser extent in Union sub-centres. UNFPA through its service delivery programmes placed midwives in Union Health and Family Welfare Centres (UH&FWC). The latter in particular in underserved areas and aimed at reaching vulnerable groups, like in the teagardens in Moulvibazar, where female workers would be more likely to go to the UH&FWC rather than the UHC which is located further away.[9] In the Chittagong Hill Tracts, UNFPA partnered with Green Hill for the provision of additional support in terms of food supplies to midway homes as well as transportation and renovation of selected health facilities in order to respond to the specific requirements of pregnant women of minority groups in the Chittagong Hill Tracks.

[9] Twelve midwives were deployed in selected Union Health and Family Welfare Centres of tea garden areas at Sreemangal Upazila, Moulvibazar in quarter 2 of 2018. UNFPA SIS Quarterly report 2018, quarter 2. In the first quarter of 2019, 73 midwifes had been working in tea garden adjacent health facilities in Moulvibazar. UNFPA SIS Quarterly report 2019, quarter 1.

Annex A-3: Results Frameworks[10]

SRHR Output Performance Data Maternal and Newborn Health

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
Outcome 1: Sexual and reproductive health and rights: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	% of live births attended by skilled birth personnel	42% (2014, BDHS)	58%	59% (2019, MICS)	BDHS 2017 report is not publicly available yet, so MICS 2019 is used to show progress against the target.
CP Output 1.1: Strengthened national policy and health sector capacity to deliver a midwife-led continuum of care and Basic Emergency Obstetric and New-born Care	National midwifery policy developed and endorsed by the Government	No (2016)	Yes	Yes: National midwifery policy was finalized and endorsed by DGNM. The Policy was also disseminated to all relevant stakeholders including midwifery educational institutions and health managers.	
	Number of upazila health complexes providing midwife-led continuum of care	0 (2016)	50	45	Source: Periodic monitoring data 2019 collected by save the Children
	Number of union health facilities in targeted districts providing 24/7 basic EmONC services	0 (2016)	180	155 Union Health and family Welfare Centre (UH&FWC) in target districts	Source: Periodic monitoring data 2019
Sub-output 1.1.1.1. Increased number and improved capacity of midwives	Number of midwives graduating from ICM standard programs within the government system	600 (2016)	4500 (excluding baseline)	2344 Furthermore, about 1500 will be graduated in December 2019	
	Number of midwives posted in areas of high needs	600 (2016)	2400 (excluding baseline)	1738 (excluding baseline), of which 1149 are registered	

[10] In order to do ensure that assessment of results of the programme covers a substantial time frame, the review of output level results below makes use of the 2019 targets compared to the results at the end of June 2019. Though this means that one cannot expect the results to be fully achieved, assessment focused on whether results had been achieved already or whether they were likely to be achieved. The rating provided should be understood as such (see color coding below).

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
				midwives. Furthermore, 944 midwives are waiting for Public Service Commission examination for deployment.	
Sub-output 1.1.1.1.1. Improved midwifery policy and legal framework	National midwifery policy developed and endorsed by the Government *(same as output 1.1.1 indicator)*	No (2016)	Yes	Yes: National midwifery policy was finalized and endorsed by DGNM. The Policy was also disseminated to all relevant stakeholders including midwifery educational institutions and health managers.	
	Availability of licensing and relicensing guidelines at BNC	No (2016)	Yes: An online system is used by BNC for lic. and relic.	Yes	
Sub-output 1.1.1.1.2. Increased capacity of faculty and improved quality of midwifery education imparted	Availability and a level of implementation of an approved faculty development plan	No plan (2016)	Yes; Plan approved, 50% of activities of an approved plan implemented	Yes: An approved faculty development plan available, and 50% of activities of an approved plan implemented.	
	Number of faculty members who have completed master's degrees in midwifery or sexual and reproductive health	0 (2016)	125	60	This concerns a cumulative achievement.
Sub-output 1.1.1.1.3 Midwives take leadership in advancing the profession	Presence of midwifery sections in the DNS and BNC	No (2016)	Yes	DGNM organogram for the midwifery section was approved as a part of the DGNM Operational Plan.	
Sub-output 1.1.1.1.4. A monitoring, mentoring and supportive supervision mechanism for midwives established	Number of CP9 districts with monitoring and supervision systems in place for midwives	0 (2016) 5 (Q1 2017)	19	12	

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
Sub-output 1.1.1.1.5. Midwifery-led care established in health care facilities	Number of upazila health complexes providing midwife-led continuum of care *(same as output 1.1.2 indicator)*	0 (2016)	50	45	
Sub output 1.1.1.2. Increased availability of quality EMONC services	Number of union health facilities in targeted districts providing 24/7 basic EmONC services *(same as output 1.1.3 indicator)*	0 (2016)	180	155 Union Health and family Welfare Centre (UH&FWC) in target districts	Source: UNFPA period data
Sub output 1.1.1.2.1. Improved national MH related policies, plans and strategies	A national strategy and action plan to address post-partum haemorrhage (PPH) and eclampsia developed and endorsed	No (2016)	Yes	Yes: The national strategy and action plan to address PPH and Eclampsia are developed, endorsed and disseminated by MoHFW. The strategy is now being implemented and monitoring by DGHS.	
Sub output 1.1.1.2.2. Strengthened readiness of facility networks for delivering 24/7 EMONC services	Number of districts which have an established network of facilities providing 24/7 EmONC services	0 (2016)	19	10 (Sylhet, Sunamganj, Barguna, Patuakhali, Rangamati, Moulvibazar, Jamalpur, Netrakona, Sherpur, and Cox's Bazar)	
Sub output 1.1.1.2.3. Increased availability of quality RH commodities (life-saving drugs) at EMONC facilities	Percentage of upazila health complexes providing EmONC services without stock outs of life-saving drugs in the last 6 months	8.1% (Q1 2017)	60%	90%	Source: UNFPA Periodic monitoring data 2019 Q2

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
Sub output 1.1.1.2.4. A harmonized EMONC information system (within MIS) is in place	Number of CP9 districts implementing MPDSR according to a national guideline	0 (2016)	19	12 (Sylhet, Sunamganj, Barguna, Patuakhali, Rangamati, Moulvibazar, Jamalpur, Netrakona, Sherpur, Cox's Bazar, Khagrachari and Bogura)	
Sub output 1.1.1.3. Increased demand for facility services by community	Number of CP9 districts achieving a 5-percent annual increase in births at public facilities	0 (2016)	19	12 (Sunamganj, Sylhet, Habiganj, Bogura, Rangamati, Khagrachari, Cox's Bazar, Moulvibazar, Noakhali, Barguna, Patuakhali and Sherpur).	Note: 2019 data will be analysed at the end of 2019.
Sub-Output 1.1.1.3.1. Increased demand for midwifery services	Percentage of women of reproductive age who identify midwives as safe birth attendants to perform deliveries	Data will be available in Decemb er2019.	Will set the target when data available in December 2019.	Nationally representative data not available. However, according to a survey conducted by BBC Media Action with a small sample size in 2018, this is found 12% of Women of Reproductive ge Group.	Note: This information will be through the UNFPA funded IEDCR's cellphone based surveillance in Sept/Oct 2019.
	Percent increase in a number of pregnant girls between 10 and 19 years of age who used midwifery services at targeted 38 MLC sites	Data not avialable	10% increase over baseline	The number of pregnant girls between 10 and 19 years of age who used midwifery services at target MLC sites has been increased by 11.7% in Q2/2019 from baseline (7035).	Data source: IP (Save the Children) periodic monitoring data)
Sub-Output 1.1.1.3.2. Community members are aware of danger signs of pregnancy	Percentage of women of reproductive age who correctly identify at least 3 danger signs of pregnancy	11.3% (2018, IEDCR)	50%	11.3% (Data Source: IEDCR's Cell Phone based surveillance	2019 data will be available in December 2019.

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
				2018)	
	Percentage of women of reproductive age who can identify three activities to prepare for birth	15% (2018, IEDCR)	80%	15.3% (Data source: IEDCR's Cell Phone based surveillance 2018)	2019 data will be available in December 2019.

Source: CO performance data

SRHR Output Performance Data Family Planning

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
Outcome 1: Sexual and reproductive health and rights Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	Percentage of demand for contraception satisfied	83.9% (2014)	87.2%	BDHS 2017 report is not publicly available yet.	BDHS: Bangladesh Demographic Health Survey
CP Output 1.2: Enhanced national capacity to increase demand for, and supply of, family planning information and services	National policy on family planning with emphasis on quality developed and endorsed	No (2016)	Yes, The policy document finalized and endorsed by government.	Yes: The National policy on family planning with emphasis on quality endorsed and disseminated by MoHFW.	
	Percentage of Union Health and Family Welfare Centers providing at least four modern contraceptive methods	82.3% (2014)	90%	98%	Data source: DGFP MIS Q2 2019
	Discontinuation rate for contraceptives among women aged 15-49	30% (2014, BDHS)	20%	BDHS 2017 report is not published yet.	
Sub output 1.2.1 Increased awareness for family planning information and services especially for modern contraceptives	Percentage of current users of modern methods, who were counselled on side effects at the time of acceptance of the method	19.3% (Cellphone based surveillance, 2016)	30%	13.7% (source: 2018 Cellphone base SRHR Surveillance, Numerator: 765 ; Denominator: 5586)	2019 data will be available in December 2019.
Sub output 1.2.1.1 Increased community awareness on FP method choices and availability of FP services by facility	Percentage of women in the reproductive age who have heard of at least four modern methods of contraception	5.1% ; (cellphone based surveillance, 2018)	20%	5.1% (Source: 2018 Cellphone base SRHR Surveillance, Numerator: 630 ; Denominator:	2019 data will be available in December 2019.

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
				12449)	
	Percentage of married female adolescents who have heard of at least three modern contraceptive methods to delay or space pregnancies	47.1% (2016)	58%	52.8% (2019 cellphone base SRHR Surveillance will start in September/ October 2019)	2018 Cellphone base SRHR Surveillance
Sub output 1.2.1.2 Increased engagement of Community Support Groups and gatekeepers to motivate community members to seek family planning services	Percentage of community members who have received FP information from community advocates	40.8% (2016)	48%	11.8% (2018 Cellphone base SRHR Surveillance,Numerator: 1326, Denominator: 11262)	2019 data will be available in December 2019.
Sub output 1.2.2 Increased access to quality family planning services and information	Adolescent Contraceptive Prevalence Rate	46.7 (2014)	55%	BDHS 2017/2018 report is not published yet.	
	Discontinuation rate for contraceptives among women aged 15-49 (Same as Output indicator 1.2.3)	30% (2014, BDHS)	20%	BDHS 2017/2018 report is not published yet.	
	Percentage of women aged 15-49, in CP9 districts, who were provided with FP information by a health worker during the last 3 months	29% (2016)	38%	17.0% (Source: 2018 Cellphone base SRHR Surveillance, Numerator: 2117 Denominator: 12449)	2019 data will be available in December 2019.
Sub output 1.2.2.1 FP policies reviewed and revised to meet the needs of the current FP context	National policy on family planning with emphasis on quality developed and endorsed *(Same as CPD Output Indicator 1.2.1)*	No (2016)	Yes, The policy document finalized and endorsed by government	Yes: The National policy on family planning with emphasis on quality endorsed and disseminated by MoHFW.	
Sub output 1.2.2.2 Improved capacity of service providers on skills and rights based counselling (on methods, side effects, follow up and referral) for pre-pregnant (including adolescents, newlyweds), pregnant (antenatal) and FP for post-partum, post abortion and post MR women	Percentage upazila health complexes where service providers are inserting PPIUDs	6.5% (Q1 2017)	35%	40.5%	Source: UNFPA Periodic monitoring data from UHCs, Q2 2019
	Availability of an action plan for postpartum family planning (PPFP)	PPFP Action Plan available (2016)	Yes, PPFP Action Plan finalized and endorsed	Yes	
Sub output 1.2.2.3 Improved availability of modern contraceptives and quality services (i.e. Compliance with guidelines and adherence to standards) in	Percentage of Union Health and Family Welfare Centers providing at least four modern contraceptive methods *(Same as CP*	82.3% (2014)	90%	98%	Data source: DGFP MIS Q2 2019

Results	Indicators	Baseline	Targets 2020	Achievements as of June 2019	Remarks
the community and health facilities (Public, Private, and NGO) in rural and urban sectors	*output indicator 1.2.2)*				
	Percentage of UH&FWCs providing at least four modern contraceptive methods in CP9 target districts	38.8% (June 2017 eLMIS)	50%	98%	Data source: DGFP MIS, Q2 2019
	Percentage of UHCs that were supervised by the FPCST	30.6% (Q1 2017 Baseline Survey)	42%	61.8%	Source: UNFPA Periodic monitoring data from UHCs, Q2 2019
Sub output 1.2.2.4 Effective use of eLMIS and MIS by DGFP, DGHS and MoLGRD, for monitoring contraceptive availability and FP performance at district and sub district levels	Percentage of UHCs without stock outs of modern contraceptives in the last 3 months	95% (LMIS 2016) 93.5% (Q1 2017 Baseline data)	99%	95.6%	Source: UNFPA Periodic monitoring data from UHCs, Q2 2019

SRHR Output Performance Cervical Cancer

Results	Indicators	Baseline	Target 2020	Achievements as of June 2019	Remarks
Outcome 1: Sexual and reproductive health and rights Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	% of live births attended by skilled birth personnel	42% (2014)	58%	59% (2019, MICS)	BDHS 2017 report is not publicly available yet.
CP Output 1.3: Increased institutional capacity to deliver integrated and equitable sexual and reproductive health services, including addressing STIs/HIV, in development and humanitarian context	Number of targeted district health facilities providing integrated SRH and GBV services	0 (2016)	19	6 (Moulvibazar, Jamalpur, Noakhali, Sirajgonj, Patuakhali and Cox's Bazar)	Note: A national protocol on Health Sector Response to GBV was developed and approved by MoHFW at the end of 2017, and in 2018 training materials were developed and accordingly training provided to 6 target districts including UHCs. Note that all remaining target districts will be covered in 2019 and training to be started from August 2019.

Results	Indicators	Baseline	Target 2020	Achievements as of June 2019	Remarks
Sub-output 1.3.5: Increased access of women to quality cervical cancer screening and treatment services	Number of women screened for cervical cancer using a VIA method in CP9 districts	4684 (DH, Q1 2017) 2660 (UHC, Q1 2017)	26889 (DH) 13613 (UHC) Total: 40,502	DH: 24439 UHC: 26683 Total: 51,122	Source: UNFPA periodic monitoring data from UHC and DH, 2019
Sub-output 1.3.5.1. A sustainable national screening programme for early detection and treatment of pre-cancerous lesion of cervix is established	Percentage of women of reproductive age group who know about cancer cervix screening	1.9% 2018, IEDCR)	10% increase from baseline	1.9 (source: 2018 Cell phone based SRHR surveillance, Numerator: 236; Denominator: 12449)	2019 data will be available in December 2019.
Sub-Output 1.3.5.1.1 A national strategy on cervical cancer prevention and treatment, with an action plan and a technical guideline, is developed	Availability of a national strategy with an action plan and a technical guideline on cervical cancer prevention and treatment	No	Yes	Yes: A costed action plan of the national strategy on cervical cancer (2017-2022) developed and approved by MoHFW.	
Sub-Output 1.3.5.1.2. A nationally agreed appropriate tier of health services supported to provide screening and treatment of pre-cancerous lesions of cervix	Percentage of facilities (UHCs & DCs) providing screening of cervical cancer by trained service providers	100% (DH, Q1 2017)	100% DHs	100% DHs	
		40.3% (UHC, Q1 2017)	71%	47.8% of a total 69 UHCs	
	Percentage of facilities providing treatment of cervical cancer by trained service providers	6.25% (DH, Q1 2017)	56.25% (DH, 9/16)	25% (4 target district hospitals are providing colposcopy and basic cervical pre-cancerous treatment)	
		0% (UHC, Q1 2017)	0% (UHC, 13/62)	0%	UNFPA is piloting a "screen and treat" approach in 3 UHCs in the last two quarters of 2019.
Sub-Output 1.3.5.1.3 Improved capacity of service providers for screening and treatment of pre-cancerous lesions of cervix	Availability of a model for decentralized screening	No (2016)	Yes: the model scaled up	Yes	
Sub-Output 1.3.5.1.4 A national cervical cancer registry established and cancer cervix data tracked through national MIS	Availability of annual cancer cervix structured report	No (2016)	Yes	Yes	

Results	Indicators	Baseline	Target 2020	Achievements as of June 2019	Remarks
Sub-output 1.3.5.2 Improved early detection, referral and treatment services for women with cancer cervix	Percentages of facilities (UHCs and DCs) providing colposcopy services	12.5% (DH, Q1 2017)	43.75% (DH, 7/16)	17% of a target 16 DHs	
		0% (UHC, Q1 2017)	0% UHCs	0% (UHCs)	
Sub-Output 1.3.5.2.1 Community awareness of cancer cervix improved through sustained SBCC programmes and campaigns	Percentage of women of reproductive age who know about cancer cervix screening	1.9% (2018, IEDCR)	5 (10% increase over baseline	1.9% (source: 2018 Cell phone based SRHR surveillance, Numerator: 236; Denominator: 12449)	2019 data will be available in December 2019.
Sub-Output 1.3.5.2.2 Referral pathway for cancer cervix is established	Number of facilities referring cancer cervix patients for treatment to tertiary institutions	8/ 16 (DH, Q1 2017)	16/16 (DH)	13 DHs	
		11/62 (UHC, Q1 2017)	25/69 (UHC)	11 UHCs referred VIA positive patients to tertiary institutions	
Sub-Output 1.3.5.2.3 Capacity of tertiary institutions improved to provide basic treatment services for cancer cervix	Number of tertiary institutions providing basic treatment for cancer cervix	6	10	10 (Dhaka MCH, Rangpur MCH, Sylhet Osmani MCH, Barishal Sher-e-Bangla MCH, Rajshahi MCH, BSMMU, National Cancer Institute, Chittagong MCH, Sir Salimullah MCH, Mymensingh MCH)	

SRHR Output Performance Obstetric Fistula

Results	Indicators	Baseline	Targets 2020	Achievements As of June 2019	Remarks
Outcome 1: Sexual and reproductive health and rights: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	% of live births attended by skilled birth personnel	42% (2014)	58%	59% (2019, MICS)	BDHS 2017 report is not publicly available yet.
CP Output 1.3: Increased institutional capacity to deliver integrated and	Number of new fistula cases operated annually	320 (2015)	2470	1088	Data source: UNFPA Periodic monitoring data, DHIS2, Hope

Results	Indicators	Baseline	Targets 2020	Achievements As of June 2019	Remarks
equitable sexual and reproductive health services, including addressing STIs/HIV, in development and humanitarian contexts Sub-output: Reduced burden of obstetric fistula through prevention, early detection, surgery and rehabilitation support					Foundation, LAMB and MAMS
Sub-output 1.3.2.1: A responsive health system for prevention of fistula developed	Number of new fistula cases identified in health facilities	81 (UNHC-62, DH-14 & MCH-5)	463	460	Data source: UNFPA Periodic monitoring data, Hope Foundation
Sub-Output 1.3.2.1.1: Increased availability and accessibility to quality skilled birth attendance at delivery	Number of Upazila Health Complexes providing midwife-led continuum of care (same as CP output 1.1.2)	0 (2016)	50	45	
Sub-output 1.3.2.1.1.1: Improved community and facility based referral services for provision of EMONC	Number of community support groups that referred women for facility delivery	0 (2017)	153	90	
Sub-output 1.3.2.1.1.2: Improved compliance with protocols for management of labor and immediate post-partum period	Percentage of facilities (UHCs & DCs) using partographs during delivery	All: 5.13% [DH: 6.3%; UHC: 4.8%] (Q1 2017)	80%	62.3%	Data source: UNFPA Periodic monitoring data
Sub-output 1.3.2.1.1.3: Increased staffing of health facilities by midwives	Number of UHCs with at least 2 midwives working	33/ 62 (Q1 2017)	50	58/69 (Q2/2019)	Data source: UNFPA Periodic monitoring data
Sub-output 1.3.2.1.2. Increased community awareness on risks associated with prolonged /obstructed labour, early recognition and referral	Percentage of women of reproductive age group who are aware of major signs of prolonged/obstructed labour and of an importance of prompt referrals	17.2 (2019, IEDCR)	5% increase from baseline	17.2 (Source: IEDCR's cell phone based surveillance, 2018; (Numerator: 2117, Denominator: 12449)	2019 data will be available in December 2019)
Sub-output 1.3.2.2 Improved capacity of a health care system to address & support women with fistula	Number of MCHs that provide treatment to fistula patients based on standard protocol	10	30	11	[1) National Fistula Center at Dhaka Medical College Hospital; 2) University Fistula Center in Bangabandhu Sheik Mujib Medical University (BSMMU); 3) Sylhet Medical College Hospital; 4) Khulna Medical College Hospital; 5) Chittagong Medical College Hospital; 6) Sher-e-Bangla Medical College Hospital, Barisal; 7) Sir Salimullah Medical College Hospital, Mitford, Dhaka; 8) Rajshahi Medical College Hospital; 9) MAMMS Institute for

Results	Indicators	Baseline	Targets 2020	Achievements As of June 2019	Remarks
					Fistula; 10) Hope Foundation Hospital; and 11) LAMB Hospital]
Sub-Output 1.3.2.2.1 Improved mechanisms for early identification of fistula cases in health care facilities and in a community	Number of women with fistula referred for better treatment to tertiary institutions/ MCHs	4 (DH-Sunamganj: 3; UHC-Ramu UHC, Cox's Bazar: 1)	143	261	
Sub-output 1.3.2.2.1.1: A national surveillance mechanism for detecting women with fistula is established	A presence of a national surveillance system on fistula	No	Yes	Yes	
Sub-output 1.3.2.2.1.2: Improved monitoring of prolonged/ obstructed labour cases for early detection of fistula	Number of district hospitals with a functional fistula corner	1 (Moulvibazar) (Q1, 2017)	19	9 (Jamalpur, Khagrachari, Netrokona, Patuakhali, Noakhali, Rangamati, Sunamganj, Habiganj and Sherpur)	
Sub-output 1.3.2.2.1.3: Fistula is included as a notifiable condition in a national registry	Inclusion of a new fistula indicator(s) into a national registry	No	Yes	Yes	
Sub-Output 1.3.2.2.2 Timely and quality surgical services are provided to fistula patients	Number of facilities (MCHs) that have trained fistula surgeons to provide timely surgical support according to the protocol	10	30	11	[1) National Fistula Center at Dhaka Medical College Hospital; 2) University Fistula Center in Bangabandhu Sheik Mujib Medical University (BSMMU); 3) Sylhet Medical College Hospital; 4) Khulna Medical College Hospital; 5) Chittagong Medical College Hospital; 6) Sher-e-Bangla Medical College Hospital, Barisal; 7) Sir Salimullah Medical College Hospital, Mitford, Dhaka; 8) Rajshahi Medical College Hospital; 9) MAMMS Institute for Fistula; 10) Hope Foundation Hospital; and 11) LAMB Hospital]
Sub-output 1.3.2.3 A functional rehabilitation system is established	Percentage of fistula survivors receiving need based rehabilitation support	0% (Q1 2017)	80%	100% (This year 65 fistula cured patients received need based rehabilitation support through three Ministries/department facilitated by LAMB (Social Welfare, Women Affairs, Youth Development)	
Sub-Output 1.3.2.3.1 Rehabilitation and support services are provided to	Number of Medical College Hospitals that have integrated	1, DMC (2016)	30	11	[1) National Fistula Center at Dhaka Medical College Hospital; 2) University Fistula Center in Bangabandhu Sheik Mujib Medical University (BSMMU); 3) Sylhet

Results	Indicators	Baseline	Targets 2020	Achievements As of June 2019	Remarks
fistula patients in need	rehabilitation services for fistula survivors				Medical College Hospital; 4) Khulna Medical College Hospital; 5) Chittagong Medical College Hospital; 6) Sher-e-Bangla Medical College Hospital, Barisal; 7) Sir Salimullah Medical College Hospital, Mitford, Dhaka; 8) Rajshahi Medical College Hospital; 9) MAMMS Institute for Fistula; 10) Hope Foundation Hospital; and 11) LAMB Hospital]

SRHR Output Performance STI / HIV

Results	Indicators	Baseline	Yearly Targets 2020	Achievements as of June 2019	Remarks
Outcome 1: Sexual and reproductive health and rights: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access					
CP Output 1.3: Increased institutional capacity to deliver integrated and equitable sexual and reproductive health services, including addressing STIs/HIV, in development and humanitarian contexts	Percentage of facility-based deliveries among people in urban slums	37% (2013) (Data source: Urban Health Survey)	50%	-	Updated data not available yet
	Number of disaster-prone districts with MISP implementation capacity	0 (2016)	22	12	
	Number of targeted district health facilities providing integrated SRH and GBV services	0 (2016)	19	6 (Moulvibazar, Jamalpur, Noakhali, Sirajgonj, Patuakhali and Cox's Bazar)	
	Number of district hospitals in CP9 districts providing STI screening and treatment services	0 (2016) 1 (Q1 2017)	19	10	
Sub-Output 1.3.1. Improved access to quality SRH services with particular focus on EmONC for urban slums dwellers	Percentage of facility-based deliveries among people in urban slums (Same as CP output indicator 1.3.1)	37% (2013)	50%	-	Updated data not available yet
Sub-output 1.3.3: Increased accessibility of comprehensive SRH services for populations affected by disasters	Number of disaster-prone districts with MISP implementation capacity *(Same as CP output indicator 1.3.3)*	0 (2016)	22	12	
Sub-output 1.3.3.1: Improved coordination and policy advocacy for SRH in emergencies	Presence of a functional SRH working group	No (2016)	Yes	Yes	

Results	**Indicators**	**Baseline**	**Yearly Targets 2020**	**Achievements** as of June 2019	**Remarks**
Sub-output 1.3.3.2: Improved national capacity to provide MISP	Number (cum.) of midwives trained in provision of 24X7 EmONC services in emergencies	0 (2016)	200	92 (cumulative)	
Sub-output 1.3.3.3: Comprehensive SRH services provided to refugees (in camps)	Percentage of (REGISTERED) refugee women, whose births were attended by SBAs	98% (2016)	100%	99.8%	Note: In 2019 as of June, out of 870 deliveries conducted in two registered refugee camps, 869 were attended by the skilled attendants.
Sub-output 1.3.4: Increased accessibility of comprehensive SRH services for GBV survivors	Number of targeted district health facilities providing integrated SRH and GBV services (Same as CP output indicator 1.3.4)	0 (2016)	19	6 (Moulvibazar, Jamalpur, Noakhali, Sirajgonj, Patuakhali and Cox's Bazar)	
Sub-output 1.3.4.1: Improved policy environment for provision of health services for GBV survivors	Inclusion of GBV in key health sector strategies/policies	No (2016)	Yes	Yes	
	Inclusion of GBV data in health MIS	No (2016)	Yes	Yes	Platform in DHIS2 (www.dghs.gov.bd/index.php/en/) is available to report GBV data from health facilities (District Hospitals, Upazila Health Complexes)
Sub-output 1.3.4.2: Improved capacity of health care providers to provide health services to GBV survivors	Number of protocols and training modules, addressing GBV issues, revised	0 (2016)	2	2	Protocol for the health care providers on health sector response to GBV, and a web-based training module
	Number of health workers capacitated in provision of health services for GBV survivors	50	1900	1334	
Sub-output 1.3.4.3: Health facilities have necessary drugs and commodities to provide services to GBV survivors	Number of UHCs with standardized rape treatment kits available	3 (Q1 2017)	133	35 (cumulative)	
Sub-output 1.3.6: Increased accessibility of STI prevention and treatment services	Number of district hospitals that provide syphilis screening for pregnant women as a part of regular antenatal care (ANC)	5 (Q1 2017)	19	12	The districts are- Bagerhat, Barguna, Barishal, Habiganj, Jamalpur, Khagrachari, Moulvibazar, Netrokona, Noakhali, Patuakhali, Rangamati and Sherpur.
Sub-output 1.3.6.1: A national STI surveillance system established	Presence of a national STI surveillance system	No (2016)	Yes	No	This is initiated with Govt. to establish a national STI surveillance system in Bangladesh. MoHFW agreed to provided budget from its' Operational Plan.
Sub-output 1.3.6.2: A national STI strategy and its costed action	Availability of a national STI strategy	No (2016)	Yes	No, but a national STI is	

Results	**Indicators**	**Baseline**	**Yearly Targets 2020**	**Achievements** as of June 2019	**Remarks**
plan developed and a guideline revised	with a costed action plan			drafted with UNFPA support in 2019.	
Sub-output 1.3.6.3: An integrated STI screening and case management provided at a district level	Number of district hospitals with a clearly established effective STI case management protocol and a referral pathway	0 (Q1 2017)	19	8 (cumulative)	
Sub-output 1.3.6.4: Improved knowledge and positive attitude to prevent from STIs among high risk groups	Percentage increase of target populations who have knowledge on common STIs including HIV	0%	6%	-	Data not available
Sub-output 1.3.7: Increased accessibility of HIV prevention services	Number of brothels that provide integrated SRH/HIV services for sex workers	0	10	11	
Sub-output 1.3.7.1 SRH/HIV integrated core service package for key populations rolled out	Percentage of Drop in Centers (DIC) providing the core package for key populations	0%	50%	27.5% (DICs available for female sex workers in Bangladesh, and UNFPA providing support in 11 DICs)	
Sub-output 1.3.7.2. Improved coverage of SRH services for people living with HIV (PLHIV)	Unmet need for family planning among the PLHIV	33% (2016)	18%	Updated data not available yet	
Sub-output 1.3.7.3 Increased availability of condoms (for dual protection)	Percentage of community clinics reporting condom stock out during three consecutive months	TBD	18%	98.5% community clinics were without condoms stock out during three consecutive months.	
Sub-output 1.3.7.4 Capacity of NASP is strengthened to better monitor and generate evidence to guide HIV programming	Availability of NASP annual reports	No (2016)	Yes	Yes	

Annex A-4: Details on Contraceptive availability

In April 2017 a fire in the central warehouse of the Directorate General of Family Planning (DGFP) burnt a huge stockpile of commodities of Family Planning services. Donations of contraceptives by UNFPA and other development partners pre-empted a stock out of some of the contraceptives. In 2018, due to procurement issues with a single source provider there occurred a stock-out of single-rod implants. In partnership with DFID, UNFPA averted a major stock out situation of implants by mobilizing 200,000 one rod implants. In 2019, the government chose to procure more expensive two rod implants. While the

country has run out of one rod implants as of now, two rod implants are available with sufficient buffer stocks.

Annex A-5: Details on Integrated SRH Services with Equity

Cervical Cancer

The Cervical cancer part of the SRHR component was originally funded primarily through regular resources. With the reduction of the regular funds received from UNFPA headquarters, this part of the programme carried some of the consequences concerned. During 2018, however, the country office was successful in mobilizing other resources from DFID, through a project focused on cervical cancer screening in 20 districts, most of which coincided with the nineteen UNFPA focus districts. When regular UNFPA funding was cut for this part of the programme, the results framework had not been adjusted as the framework had just been agreed at the start of 2017 between UNFPA and GOB. Given fund limitations, national level activities were prioritized. With additional funding realized from DFID in Q1 2018 which will last till 2022, the country office is confident that towards the end of 2020 most of the targets as included in the CPAP results framework can be met. Reporting on cervical cancer started in Q4 2017.

UNFPA focused on both the supply and the demand side. In terms of the supply side support was provided to enhance capacities at national and facility level to provide screening and treatment related services and establishment of a referral pathway. Demand related support focused on enhancing community awareness concerning cervical cancer and opportunities for screening and treatment. UNFPA, together with national and international partners, supported the development of the national strategy for cervical cancer prevention and control, which was approved in Q2 2018, after which UNFPA in cooperation with WHO supported the development of a costed action plan for its implementation. Moreover, support interventions at sub-national level were started on a limited scale. A prevalence study amongst tea plantation workers in Sylhet division found that cervical cancer concerns a significant health issues for this marginalized groups with 19 percent prevalence rate based on Visual Inspection by Acetic Acid (VIA) screening. UNFPA followed up these results with support to Moulvibazar district hospital in the conduct of secondary screening of the VIA cases identified.

In terms of CPAP output level indicators, targets on strategy, annual reporting, basic treatment at tertiary level and screening at district hospital level were met, but screening at UHC and advanced screening and treatment at DH could not be met.

Obstetric Fistula

The reduction of UNFPA regular resources to the Bangladesh country office also affected the fistula component of the SRHR outcome area, with a reduction of funds to implement activities concerned. With additional resources for cervical cancer secured, the funding gap in fistula remained the largest concern as part of the SRHR outcome area.

The fistula component focused on identification, treatment, rehabilitation and reintegration of patients in society, with identification done by the MOHFW, treatment through Medical College Hospitals and NGOs including LAMB and HOPE and rehabilitation and reintegration conducted in close cooperation with the Ministry of Women and Children Affairs. Obstetric fistula occurs usually outside of health

facilities, in home deliveries. Occurrence is higher where women have less access to reproductive health services, including in Sylhet, Rangpur and Chittagong.

UNFPA supported the development of the second National Strategy for Obstetric Fistula 2017-2022, which aims at reaching zero fistula patients by 2030. UNFPA worked with EngenderHealth to develop guidelines for identification and management of women with persistent fistula related disorders. Use was made of community support systems in identification of patients at the local level. UNFPA worked with medical college hospitals, LAMB hospital and Hope Foundation Hospital to support the treatment and rehabilitation of fistula patients. Eleven institutes provide fistula care with a total of about 700 women per year treated. However, in order to eradicate fistula, the patient load is estimated to need to be at 2,000 cases per year. In the third quarter of 2018, fistula indicators were include in the registry (DHIS2) of DGHS.

The NGO LAMB has made a clear linkage in their programming between fistula incidence and child marriage, both being high in Char areas where education levels are relatively low and communication in large parts of the year poor. In this respect they focus on prevention of child marriage as a means to reduce the obstetric fistula prevalence rate.

Though fistula as such is not a main contributor to MMR to which it contributes about 3 percent[11], the focus on fistula is justified in terms of focus on a specifically vulnerable and marginalized group, with a specific relation to the mandate are of UNFPA. Women with fistula in Bangladesh are often left by their husband and shunned by their families and communities. Some patients have been living with fistula for decades. The number of fistula patients in Bangladesh is relatively high with an estimated 20,000 cases and a yearly increase of 1,000 new cases. The exact present incidence of fistula is not known. The fact that the known cases are increasing is not necessarily related to increase of incidence, but can be related to enhanced reporting and identification of cases concerned.

In terms of targets of the CPAP results framework, those on identification of patients were met, including the development of a national surveillance system for fistula and targets on referral as well as those on rehabilitation received by fistula survivors met. However, targets on fistula surgeons and treatment provided in medical college hospitals were not met. The number of district hospitals with a functional fistula corner has been improving, and fistula was included with indicators in the national registry, though reporting standards remained low.

While the UNFPA programme provides support to address obstetric fistula, which appears to be decreasing, surgical fistula which is caused by surgical mistakes and appears amongst others related with the high incidence of C-sections, is increasing. Complication concerned is that most of the C-sections occur in the private sector, resulting in a lack of good national data on issues concerned. Increase in prevalence of surgical fistula could also be related to enhanced accountability of doctors, with an increasing amount of cases recognized as such.

Maternal and Perinatal Death Surveillance and Response

[11] Maternal mortality survey, unpublished.

UNFPA has provided support to the Maternal and Perinatal Death Review and Response since 2010, which is presently a GOB programme, led by the MPDSR committee at district level. The committee conducts review of deaths which are suspected to be maternal deaths and conducts a social autopsy. When the results of the review started to show an increase of maternal deaths, the review also included a response, i.e. actions at district level to take to reduce the maternal mortality rate. The number of districts supported by UNFPA have increased from 5 in 2017 to 12 districts in 2019 and coverage of all 19 UNFPA focus districts planned by 2020. Once the MPDSR system can provide sufficiently rigorous data, the maternal mortality survey will no longer be needed. The Maternal and Perinatal Death Review data are important to guide the support provided to MNH.

Other SRH Services

A last set of SRH services under the equity component include sexually transmitted infections (STIs) and HIV, health sector response to GBV and access to SRH services for urban slum dwellers and populations affected by disaster. All these initiatives are aimed to contribute towards an enhanced institutional capacity to deliver integrated and equitable SRH services.

Prevention and treatment of STI/HIV

UNFPA Programme initiatives focused at increased accessibility of STI prevention and treatment services in particular for high risk groups, increased accessibility of HIV prevention for key populations and access to SRH services for key populations and people living with HIV.

UNFPA supported the update of the STI case management protocol from 2006 and strengthened capacity for syphilis screening for pregnant women as part of regular antenatal care. UNFPA supported the second national stigma study together with UNAIDS, UNICEF and PHLIV network, which focused on the stigma experienced by people living with HIV in Bangladesh in order to enhance the evidence base for advocacy and programme development.

With government services suspended, UNFPA worked with UNAIDS, UNICEF and WHO to support the provision of SRH services for brothel based female sex workers and enhance referral linkages with district health, family planning, law enforcement and women affairs departments at the local level. More recently, UNFPA partnered with the NGO Lighthouse who worked with change agents and community based organization of local sex workers in order to enable access to SRH services. Limitation concerned that male partners and clients of sex workers were not included in the programme and support to change agents appeared to have stopped.

Health Sector Response to GBV

This part of the programme focused on access to comprehensive SRH services for GBV survivors, through enhanced regulatory environment, improved capacity of health care providers to provide services to survivors and enhanced capacity of health facilities in term of drugs and commodities required to provide SRH services to GBV survivors.

UNFPA supported the development and dissemination of the national protocol on Health Sector Response to GBV for health service providers, approved in September 2017, something which had been missing so far, and supported its implementation through development of the capacities of health

service providers in six district and sub-district facilities. The protocol includes services to be provided including physical examination, treatment and multi-sectoral references. It makes use of a confidential and non-judgmental approach towards victims of GBV. UNFPA has provided standardized guidelines on clinical management of rape and supported the supply of necessary commodities, including rape management kits, in selected sub-district hospitals in order to strengthen services for survivors of gender-based violence. UNFPA has been supporting registry of GBV survivors and to enhance the District Information Management System in this respect. A One Stop Crisis Center unit is setup is nine Medical College Hospitals with 40 One Stop Crisis Cells in district hospitals and 20 cells in upazila health complexes. While the centers provide services to GBV survivors, the cells can refer survivors and provide information.

SRHR in Urban slums

Work on urban slums started more recently and was aimed at improving access to quality SRH services for urban slum dwellers, with focus on EmONC services.[12] This part of the programme focused on urban slums of Dhaka City Corporation, with community health workers trained to provide SRH related messages to women and their families. In order to support the community health workers, a mobile phone based application was developed that supported the health workers with both communication skills and information on SRH topics including family planning, antenatal care, birth preparedness, maternal and neonatal danger signs and institutional delivery. This part of the programme is small in setup as it worked with 40 community health workers so far.

The partnership setup of the support differs from other parts of the programme as health services in the urban setting have a different governance structure. In terms of health services in urban areas, roles and responsibilities are divided among the Ministry of Local Government Rural Development and Cooperatives, MOHFW and urban governments. Therefore, urban programming will require UNFPA to develop new relationships with different government agencies to enable work in urban settings. In the urban areas the private health sector is more prevalent, with about 60 percent of their services are provided in urban areas.[13] Several development partners and civil society organizations have been supporting urban health. Presently 35 percent of the population resides in urban areas (data 2016) and the expectation is that by 2050 the urban population will account for more than half of the population of Bangladesh.[14]

Coverage of the various parts of the SRHR programme

- MPDSR 5 districts in 2017, 12 in 2019 (June) and 19 by 2020
- Focus districts 19
- Disaster prone districts 22 (SIS 2018)
- Cervical cancer 20 districts of which 11 overlap with UNFPA focus districts
- HIV incidence higher in 23 districts

[12] A recent census of GOB counted about 14,000 slum settlements across the country in Bangladesh with shared characteristics as high population densities, large share of migrants from rural areas, inferior public water and sanitation services, and poor-quality housing, which creates greater health challenges for their residents. Knowledge about urban health remains sparse. Govindaraj, Ramesh, Dhushyanth Raju, Federica Secci, Sadia Chowdhury, and Jean-Jacques Frere. 2018. Health and Nutrition in Urban Bangladesh: Social Determinants and Health Sector Governance. Directions in Development. Washington, DC, 2018.

[13] Interview data.

[14] UN DESA in: Govindaraj, Ramesh, Dhushyanth Raju, Federica Secci, Sadia Chowdhury, and Jean-Jacques Frere. 2018. Health and Nutrition in Urban Bangladesh: Social Determinants and Health Sector Governance. Directions in Development. Washington, DC, 2018.

Annex B-1: A&Y Performance Data

Output 5: A&Y Performance Data

Outcome 2:	**Milestones**	**Baseline**	**Target**	**Performance as of June 2019**	**Remarks**
Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	Percentage of women 20-24 years old married before 18	59% (2014)	40% (2020)	BDHS 2017 report is not publicly available yet.	BDHS: Bangladesh Demographic Health Survey
	Number of laws, policies and strategies that allow all adolescents and youth access to sexual and reproductive health information and services	1	4	5 These include- 1) The National Youth Policy; 2) The National Action Plan for the Youth Policy; 3) The Adolescent Health Strategy and the Action Plan; 4) The National Plan of Action to Eliminate Child Marriage; and 5) The Secondary Education Sector Plan	
Output 2.1: Increased capacity to implement evidence-based policies, strategies and services for adolescents and youth including sexual and reproductive health and rights, gender responsive life skills education, and prevention of child marriage	A national curriculum on gender-responsive life skills education developed and endorsed by Government	No (2016)	Curriculum endorsed by the government (2020)	Yes: The competency based learning materials (CBLM) are finalized and approved by the National Skills Development Authority (NSDA). The mapping of life skills education in secondary schools is also completed and approved by NCTB.	This indicator is also used as Sub-Output 2.1.1.1 indicator.
	Number of service delivery points with at least one trained service provider who can provide adolescent-friendly sexual and reproductive health information and services in selected districts	10 (2016)	600 (2020)	544	
	A costed National Plan of Action to eliminate child marriage developed and budget allocated	No (2016)	Yes (2020); A costed National Plan of Action to eliminate child marriage developed and budget allocated	National Plan of Action (NPA) to Eliminate Child Marriage finalized, approved and disseminated by MoWCA. The costing exercise is awaiting the development of the M&E framework, by UNICEF.	This indicator is also used as Sub-output 2.1.3.1 indicator.
Sub-Output 2.1.1. Gender-responsive life skills and SRH education (LSE) is integrated into vocational	Availability of a government circular recommending the inclusion of life skills	No (2016)	Yes (2020): A circular issued by the National Skills	No (a government circular will be available later in 2019).	

Outcome 2:	**Milestones**	**Baseline**	**Target**	**Performance as of June 2019**	**Remarks**
training and general education	education in all Government supported TVET programmes in Bangladesh		Development Authority (NSDA) Secretariat		
Sub-output 2.1.1.2: Relevant educational/training institutes have the capacity to provide life skills education to young people in CP9 districts	Number of education/training institutes teaching gender responsive life skills education according to developed circular	0 (2016)	350 (2019)	350 (The Generation Breakthrough project has continued to provide gender responsive life skills education in 350 institutes).	The GB project (350 schools) will end in 2019.
Sub-output 2.1.1.3. Communities are supportive of young people, especially young girls, receiving life skills education in CP9 districts	Number of community stakeholders supporting LSE for young people, especially girls	14 (Q1, 2017)	5663 (2020)	4869	
Sub-Output 2.1.2. Health systems better equipped to deliver age and gender sensitive SRHR information and services	Percentage of adolescents and youth, both female and male, using SRH information and services in the CP9 districts who are satisfied with the services and facilities	Not available	60% (2020)	90.1%	Cell Phone based surveillance report 2018, IEDCR (N=886, n=798)
Sub-output 2.1.2.1 The National Adolescent Health Strategy and costed National Plan of Action 2017-2030 finalized	A National Adolescent Health Strategy finalized and costed	No (2016)	Yes (2020): A National Adolescent Health Strategy finalized and costed	The costed action plan of National Adolescent Health Strategy finalized.	
Sub-output 2.1.2.2. Health service providers equipped with skills to deliver gender and age sensitive SRHR information and services according to Essential Service Delivery package and AFHS Corner Operational Guide in CP9 districts	Adolescent contraceptive prevalence rate	46.7 (2014)	55 %	BDHS 2017 report is not publicly available yet.	
	Percent increase in a number of pregnant girls between 10 and 19 years of age who used midwifery services at targeted 38 MLC sites	16.7% (2017)	10% increase over baseline	The number of pregnant girls between 10 and 19 years of age who used midwifery services at target MLC sites has been increased by 11.7% in Q2/2019 from baseline (7035).	Data source: IP (Save the Children Periodic Monitoring Data)
Sub-output 2.1.2.3. Evidence on effectiveness of available AFHSs generated	Number of policy dialogues/seminars/policy briefs/strategies/ plans that use results of the assessments on effectiveness of health services to deliver adolescent-friendly health services	0 (2016)	9	6 These include- a)two policy dialogues based on the findings of the assessment of the effectiveness of adolescent friendly health service corners; b) National Adolescent Health Strategy dissemination; c) a policy	

Outcome 2:	**Milestones**	**Baseline**	**Target**	**Performance as of June 2019**	**Remarks**
				brief on the status of adolescent sexual and reproductive health; d) a policy dialogue on International Youth Day (IYD) findings from assessments on the AFHS in relation to making health services safe for young people was a key focus; e) a policy brief on urban adolescents; and f) a review of needs and practices related to sexual and reproductive health)	
Sub-output 2.1.2.4. Young people are aware and communities are supportive of young people seeking SRHR information and services in CP9 districts	Percentage of adolescents who know the places within their reach to comfortably seek ASRHR services	15.3% (2015)	35% (2019)	28.4%	Data source: Midline survey of Generation Breakthrough project.
	Number of adolescents who participated in SRHR sessions and became aware of places within their reach to comfortably seek ASRHR services	19,252 (2015)	117,000 (2019)	128,385	This includes multiple count because the SRHR sessions in schools do not include a formal register.
	Number of community stakeholders supporting young people's access to SRH services	0 (2016)	1443 (2019)	2398	
Sub-output 2.1.3.2. Evidence on child marriage for use in effective policy and programme planning and implementation generated	Number of policy dialogues/seminars/policy briefs/strategies/plans that use results of studies on child marriage for policy actions/decisions/ recommendations	0 (2016)	10 (2020)	6 These include- a) A policy brief based on the child marriage study conducted by Dhaka university; b) a policy dialogue on child marriage; c) the importance of investing in education for girls; d) A policy brief on the findings of the baseline study; e) community assessment brief; and f) the baseline survey findings dissemination.	
Sub-output 2.1.3.3. Strengthened monitoring capacity of the national coordination body to monitor implementation of the National Action Plan to Eliminate Child Marriage	A national database on Violence against Women expanded to include child marriage data and is functional	No (2016)	Yes: National database functional with links to appropriate referral services	No	

Outcome 2:	Milestones	Baseline	Target	Performance as of June 2019	Remarks
Sub-output 2.1.3.4. Increased acceptance of the legal age of marriage and the importance of investing in adolescent girls' education/vocational skills in CP9 districts	Number of community stakeholders supporting girls getting married after 18	0 (2016)	779 (2019)	835	
Sub-output 2.1.3.5. Safe and more girls' friendly environments for girls to attend and be in schools in CP9 districts	Number of schools and madrasahs with a functional anti-sexual harassment committee	12 (Q1/ 2017)	72	72	The anti-sexual harassment committees in all 72 target secondary schools in the Jamalpur and Bogura districts.

Source: UNFPA Bangladesh SIS Report 2017, 2018 and 2019 (Q1 and Q2), and Periodic Monitoring Data

Annex C-1: Gender Equality Performance Data

Output GEWE Performance Data

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

Outcome indicator: *Percentage of ever married women age 15-49 who agree that a husband is justified in hitting or beating his wife with at least one specified reason

Baseline: 28.3% (2014)**; Target (2020):** 23%; **Achieved (2019 2nd quarter) : 25.4 (MICS 2019)**

Output 3.1: A national mechanism operationalized to plan, coordinate and monitor strategies, policies and protocols to address gender-based violence and harmful practices

Sub-outputs:

3.1.1 Improved policy and legal framework to prevent GBV: Costed National Action Plan RRF is in place
3.1.2 Strengthened monitoring capacity of the national coordination body to monitor the implementation of NAP and relevant policies
3.1.3 Strengthened capacity of labour inspectors to advise on addressing GBV and SRHR at workplaces
3.1.4 In-depth analyses of data on VAW/GBV are available to inform planning and decision making
3.1.5 Increased awareness of decision makers on GBV and SRHR related recommendations of UPR and CEDAW
3.1.6 GBV and harmful practices integrated into national in- and pre-service training by national training institution

Indicators	Baseline	Target	Performance as of June 2019
Output indicator 1. A costed annualized results framework to operationalize the National Action Plan to prevent violence against women and children is in place	No (2016)	Yes (2020): The costed annualized result framework approved by MoWCA by 2020	NAP-VAW (2018 – 2030) was revised, approved and disseminated by MoWCA in 2018 In Q2/2019, UNFPA hired an organization to support the development of a costed results framework following the approved NAP-VAW (2018-2030).
Output indicator 2. Number of ministries and departments that have developed/strengthened a gender equality strategy	1 (2016)	4 (3 new)	Achievements: 3 1. DIFE's GBV and SRHR module; 2.Diploma midwifery syllabus and training courses of DGNM

		(2020)	3) Police Staff College training module (baseline) The remaining one (Police Foundation Training Academy) is planned in 2020).
3.1.1 Number of ministries and departments that have developed/strengthened a gender equality strategy	0 (2016)	3 finalized GBV strategies available (2020)	Achievements: 2 1). MoHFW Gender Strategy, and 2) MoLE's GBV strategy and its operational guideline. Another one is planned for the Bangladesh Police. UNFPA continues its' advocacy with the Bangladesh Police to develop a gender equality strategy but realized that this is a very high level policy issue and extensive discussion/dialogues needed.
3.1.2 Presence of a monitoring mechanism for VAW National Action Plan (NAP)	No (2016)	Yes (2020): The mechanism for monitoring the NAP disseminated	In Q2/2019, UNFPA hired an organization to support the development of an M&E framework following the approved VAW NAP. A framework drafted for discussion with 12 relevant ministries..
3.1.3a Number of policies/rules/regulations/checklists/ protocols promoting SRHR and GBV prevention at a workplace	1 (2016)	3 (2 new) (2020)	Achieved 1). Bangladesh Labour Rule for the prevention of GBV and sexual; 2) Factory Inspector Checklist of DIFE; 3) Protocol for the Health Sector Response to GBV
3.1.3b Percentage of labour inspectors who have increased knowledge on revised rules/policies/checklists, which integrated SRHR and GBV	0%	80% (2020)	100% achieved in 2018. N=18 labour inspectors 72% achieved in Q2/2019. N=40 labour inspectors
3.1.3c Number of private companies that received recommendations from labour inspectors related to GBV and SRHR	0 (2017)	20 (2020)	8 private companies received recommendations from the Labour Inspectors 2nd Q of 2019 . There were none in 2017 and 5 in 2018. Late start could have been due to shift in partnership from Ministry of Labour and Employment (MoLE) to Department of Inspection for Factories and Establishments (DIFE). Now it is more or less in track.
3.1.3d Number of Industrial Police Officers who demonstrate increased knowledge and skills to address GBV at workplaces	0 (2016)	75 (2020)	This relevant activities could not be implemented in 2017 due to delays in the approval process of TAPP). 2018 target not achieved. 40 achieved by Q2 2019.
3.1.4a Number of reports of in-depth analyses on VAW/GBV	0 (2016)	4 (2020)	Two reports by Dhaka University on GBSS in 2018. 1 new report in 2019. A draft report on the study on key drivers of GBSS, its' causes and consequences using primary data produced in 2019 Q2. Target not achieved yet, but in track.
3.1.4b Number of policy dialogues/seminars/policy briefs/strategies/plans for policy decisions/ actions/recommendations	0 (2016)	9 (2020)	3 achieved in 2017. 3 achieved in 2018. 1 achieved in Q2/2019. (One policy dialogue was conducted on Sexual Harassment Law and High Court directives 2009 with the Parliamentary Standing

			Committee of the Ministry of Women and Children Affairs). Target not achieved yet, but in track.
3.1.5 Inclusion of SRHR and GBV issues into the government reports on UPR and CEDAW	No (2013 UPR)	Yes (2020): SRHR and GBV issues are adequately addressed in the UNCT and CSO CEDAW report	SRHR and GBV issues were included in both UNCT and CSO stakeholders report shared with NHRC and MoWCA in 2017 UPR report. In 2018, the Civil Society Organizations Forum submitted its third cycle Universal Periodic Review report to the UN Human Rights Council (UNHRC). In addition, MoWCA's DWA disseminated the recommendations on GBV and SRHR issues to relevant stakeholders received from UNHRC. In 2019, an implementation plan on UPR recommendations for MoWCA developed, now waiting for MoWCA approval.
3.1.6 Number of national training institutions that integrate a module on GBV/harmful practice into pre-/in-service training *(same as CDP output indicator 3.1.2)*	1 (2016)	4 (2020)	Cumulative achievement: 3 (including baseline); 1. DIFE's GBV and SRHR module; 2.Diploma midwifery syllabus and training courses of DGNM 3) Police Staff College training module (baseline). One more training module on Police Foundation Training Academy is planned in 2020.
Output 3.2: Increased availability of information and services to prevent and address gender-based violence and harmful practices, in both development and humanitarian settings Sub Outputs: 3.2.1: Referral systems (multi-sectoral coordination) functional at district levels 3.2.2 Improved availability of women friendly police service 3.2.3 GBV cluster operationalized to coordinate GBV multi-sectoral prevention and response 3.2.4 Minimum Standard (MS) for prevention and response to GBV in emergencies (GBViE) implemented			
Indicators	**Baseline**	**Target**	**Performance as of June 2019**
Output indicator 3.2: Number of districts with functional referral mechanisms to provide coordinated and comprehensive services for GBV survivors, including in humanitarian settings	0 (2016)	5 (2020)	1 (Cox's Bazar) in 2017. 4 (Cox's Bazar, Bogura, Patuakhali and Jamalpur) in both 2018 and 2019.
3.2.1 Number of districts that are collecting service utilization data on GBV through an information database	0 (2016)	5 (2020)	1 (Cox's Bazar) in 2018.2 (Cox's Bazar and Jamalpur) in 2019.
3.2.2a Number of police stations adhering to SOP of women-friendly police	44 (2016)	51 (2020)	51 police stations have been continuing to follow the SOP for Wo men-friendly police stations. Target achieved.
3,2,2b Number of women who received services from Women Help Desks (WHDs)	790 (2016)	5612 (2020)	**Cumulative achievement (from 2017-June 2019): 11,033 (**followed by 1312 in 2017, 4505 in 2018, and 5,216 in 2019 as of June).

3.2.2c Percentage of women who were satisfied with WHD services	61.7% (2017)	65% (2020)	71% achieved in 2018 target achieved. Will be updated in December 2019. A survey will be conducted at the end of December 2019.
3.2.3a Existence of a functional GBV Cluster with UNFPA leadership at national and district level	No (2016)	Yes (2020): GBV cluster functional at national and district level	UNFPA continues to maintain leadership of the GBV Sub sector in cox's Bazar. Regular biweekly. In this quarter GBV national cluster was actively engaged in emergency preparedness and response with the leadership from UNFPA and Ministry of Women and Children Affairs. GBV national cluster continues its effort to review the assessment tools by different cluster and working groups throughout the quarter.
3.2.3b Number of clusters/working groups collecting GBV related information in assessments, monitoring, and addressing GBV issues in response plan	0 (2016)	4	4
3.2.3c Percentage of emergencies where the GBV Cluster articulated its own needs assessment and response plan as part of HCTT JNA and HRP if any	0% (2016)	100% (2020)	100% achieved. The GBV Sub Sector participated in the process of the humanitarian needs overview which led to the articulation of the Joint Response Plan (JRP) for 2020. The need for GBV prevention and response were well identified and the GBV response plan shared with the Inter-sector Coordination Group (ISCG). The response plans for both Cyclone and monsoon covered the needs and priorities actions identified by the GBV Sub Sector. GBV cluster articulated its own needs in joint need assessment and the response plan. Every phase of the need assessment GBV cluster was involved like data collection and analysis. GBV national cluster strongly advocate for articulate the GBV response as lifesaving need in response plan which was considered as evidence to facilitate the resource mobilization by members.
3.2.4 Number of target districts that have implemented relevant specific actions in line with selected Minimum Standards	0 (2016)	4 (no new)	2 (Cox's Bazar and Bogura) "Depends on emergency hit districts" 2018

Output 3.3 Positive changes in gender norms, including intolerance of GBV, in communities.
Sub Outputs:
3.3.1 Advocacy and SBCC plan for GBV prevention developed and implemented
3.3.2 Increased male engagement, including youth, in GBV prevention and SRHR promotion
3.3.3 Faith based organizations are actively engaged in preventing GBV
3.3.4: A community protection mechanism/Nari Nirjaton Protirodh Committees (NNPC) for addressing GBV in normal humanitarian settings is functional
3.3.5 Strengthened partnerships with CSOs and private sector on advocacy for addressing GBV

Indicators	Baseline	Target(2020)	Performance as of June 2019
3.3.1 Advocacy and social behaviour change communication (SBCC) plan for GBV prevention developed and implemented	No (2016)	Yes (2020): Advocacy and SBCC plan implemented in 5 target districts and effectiveness of the SBCC plan validated	Not achieved according to 2018 report. No updates in 2019 Q2. A formative research is planned to support the development of a SBCC plan is planned in Q4 2019.
3.3.2 Number of men and boys engaged in GBV prevention and SRHR programmes	0 (2016)	250 (2020)	**1,456** men and boys (followed by 225 in 2018 and 1,231 as of June in 2019) were engaged in GBV prevention activities such as male gathering, engagement of youth and projection of videos to aware men & boys on harmful gender norms and practices including their roles in preventing gender based violence.
3.3.3 Number of religious leaders engaged in GBV prevention	0	75 (2020)	Not included in 2017,2018 and 2019 SIS as this activity is dropped from this country programme. However it was observed from the field that some religious leaders were incorporated in meetings of NNPC.
3.3.4 Number of functional Nari Nirjaton Protirodh Committees (NPPC)/social protection groups in CP9 districts	2 (Q1 2017)	35 (2020)	122 Nari Nirjaton Protirodh Committees (NPPC) are functional and conducted meetings jointly with the Department of Women Affairs of MoWCA and ASTHA project of UNFPA in 4 districts. 122 Target achieved It may be mentioned that Q2 2019 report gives detailed comments on some very proactive informed decisions taken by NNPCs. Furthermore it states that a guideline has been prepared and circulated in project districts to improve reporting and documentation mechanism for NNPCs. One government letter from DWA has also been issued in this regard. These developments are commendable. It is further suggested that some of the statistics of the P and D section of UNFPA could be circulated through these forums to bolster their existing work.
3.3.4 Number of GBV and child marriage cases addressed by NPPC/SPG/CWG	GBV=2 ECM=6 (2017)	100 (2020)	72 GBV and child marriage cases addressed by the NNPC with the support of DWA by Q2/2019 followed by 8 in 2017, 32 achieved in 2018 and 32 as of June in 2019.

3.3.5 Number of CSOs ally with UNFPA to advocate on GBV prevention and response	0 (2016)	31 (2020)	31 CSOs are currently allied with UNFPA By Q2/2019, more CSOs will be included through GBV sub cluster formation in Patuakhali and Bogura. *Target achieved*
3.3.5 Number of private companies partnering with UNFPA on GBV prevention at workplaces	0	2 (cumulative)	Not targeted in 2017 & 2018. However 1 planned in 2019 with Picard Bangladesh.

Source: CO performance data

Further achievements under the gender component are:[15]

A web-based online Clinical Management of Rape (CMR) module in Bengali language was developed 4,505women and girls received GBV-related services from Women Help Desks (WHD) in 24 police stations and 4 courts in 04 districts. 72% of the respondents reported a high level of satisfaction with the services from WHDs. Fifty-one (51) police stations (district level and Dhaka Metropolitan) adhered to the Standard Operating Procedures (SOP) on combating gender based violence and provided services to women and girls as per SOP. Introduction and establishment of referral mechanisms and GBV case management system in the development setting was a first ever initiative in Bangladesh. 1,334 women and girls provided with multi-sectoral GBV referral services and in 2018, 308 GBV cases were managed in 4 project districts. Under the secondary data analysis of VAW data to prevent GBV and harmful practices, a study on Gender Biased Sex Selection/Son preference was initiated and mostly funded by GEWE which was implemented by the University of Dhaka through the P&D unit

In Q2 2019 total of 598 survivors used services from different GBV related services form Court Help Desks (133), Women Help Desks at police stations (358) and Women Friendly Spaces (107) including medical referral, psychosocial support, and justice and policing and referral linkage to legal services.[16] According to the CPE Annex document and UNFPA Systematic Information System (SIS) Quarterly Report 2019, 122 functional VAW Committees (NNPCs) have been formed to date. The breakdown is 103 at the Union level, 12 in the Upazila levels, 3 in the Municipality (pourashava) level and 4 at the district level.

[15] Debriefing by Gender Unit, UNFPA, 27th July 2019, UNFPA Bangladesh Annual Report, 2017, 2018

[16] Output performance data, Q2, 2019, UNFPA

Annex D-1: P&D Performance Data

P&D Summary Performance Data

Outcome 4: Population dynamics
Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.
Outcome indicator:
Number of new national development plans that address population dynamics by accounting for population trends and projections in setting development targets.

Baseline: 0 (2016); Target: 3 (2020); Achievement: 1 (2019 as of June)- Bangladesh Delta Plan 2100 that explicitly reference demographic dynamics, including changing age structure, population distribution and urbanization.

In addition, 8th Five Year Plan of the Government (2021 – 2025). A range of recommendations generated through policy dialogues, expert groups consultation, GED documented them and published them as analytical pieces. In addition, UNFPA is undertaking a comprehensive analysis of demographic dynamics for development in Bangladesh which will be one the 20 background documents for the 8th Five Year Plan.

***Output 4.1*: Increased capacity of national institutions to further dis-aggregate analyses and disseminate quality population data in a timely and user-friendly manner to inform evidence-based planning, budgeting and monitoring progress. (*Four sub-outputs and their indicators are below*)**

Sub-outputs:
4.1.1: SDG and 7th FYP monitoring framework developed and used for tracking progress
4.1.2: Improved census and survey methodologies to allow collection and analysis of good quality disaggregated population data and their timely release
4.1.3: REDATAM platform is expanded to increase public access to data produced by NSO
4.1.4: GIS is used for in-depth spatial analyses of population data for planning and monitoring in both development and humanitarian contexts FY

Indicators	Baseline	Target	Performance as of June 2019
Output indicators: **4.1.1:** A SDG and 7th Five-Year Plan monitoring and reporting framework put in place with UNFPA's support	0 (2016)	2 (2020)	The General Economics Division (GED) of Bangladesh Planning Commission developed the SDGs' M&E Framework based on several consultations to identify data sources of SDG indicators, to set multi-year targets and to map ministries responsible for the implementation of specific targets, aligned with 7th Five Year Plan (2016-2020). UNFPA as an active member of the UN Data Group played an important role to include UNFPA mandated indicators in the framework. UNFPA also provided technical support to GED through their meetings with UN Data Group and written comments to improve the framework. UNFPA is working with its government Implementation Partners to establish a comprehensive data collection and management mechanism to monitor and report on their relevant SDG indicators. SDG focal persons (85, during 2017=2019) of different ministries are oriented on their responsible SDG indicators. Data sources and availability reviewed with BBS (Support to establishment of SDG Cell at BBS to help report on SDG indicators using the

			ministries' administrative data) Besides, under GED project, 3 workshops conducted to enhance the capacity of Focal Persons to harmonize SDGs action plans of respective Ministries/Divisions in line with the core principles of SDGs, inter-linkages of indicators including availability of data sources, construction of indicators, reporting of metadata and disaggregation of data, etc. 7th FYP monitoring and evaluation framework are put in place. UN Data Group (where UNFPA co-chairs the group and an active member) played a role in including UNFPA mandated indicators in the framework.
4.1.2: A Population Census 2021 Master Plan with resource requirements developed and endorsed by the Government	No (2016)	Yes (2020)	The Bangladesh Bureau of Statistics (BBS) developed and finalized the master plan for 2021 Population and Housing Census in 2018 with UNFPA technical support. This plan was prepared through a consultative process and pre-testing of the questionnaire and methodology at the field level which will be used to conduct the next round of Population and Housing Census using multimodal data collection approach in 2021. More exercises will take place in 2019 to make this effort a success. Following the master plan, BBS has also developed a detailed project proposal (DPP).
4.1.3: Number of national databases with population-based data that facilitate mapping of socio-economic inequalities and demographic disparities accessible by users through web-based platforms.	3 (2016)	9 (2020)	Nine data bases were uploaded and disseminated through a REDATAM web portal that will also help facilitate mapping of socioeconomic and demographic disparities in the country. Availability of the demographic data by age and sex, location disaggregation has thus increased among the data users for research and planning purposes. . The datasets are- Sample Vital Registration System-SVRS 2010, Economic Census 2013, MICS 2013, HIES 2010, Economic Census 2013, SVRS 2016, Slum Census 2014, VAW Survey 2011, VAW Survey 2015, and Population Census 2011 (short and long questionnaire.
Sub-output indicator 4.1.1: A SDG and 7th Five-Year Plan monitoring and reporting framework put in place with UNFPA's support	0 (2016)	2 (2020)	Same as CPD output indicator: 4.1.1
Sub-output indicator 4.1.2			
1) A Population Census 2021 Master Plan with resource requirements developed and endorsed by the government	No (2016)	Yes (2020)	Same as CPD Output indicator 4.1.2
2) Number of population surveys that include appropriate methodologies with UNFPA's support	0 (2016)	5 (2020)	3 (1. Exploring Gender-Biased Sex Selection in Bangladesh: A Review of the Situation 2. Demographic Profiling and Needs Assessment of Maternal and Child Health (MCH) Care for the Rohingya Refugee Population in Cox's Bazar, Bangladesh" 3. Marriage and sexual and reproductive health of Rohingya adolescents and youth in Bangladesh: a qualitative study)
3) Availability of geo-coded digital small-area maps for the entire country	No: 29 districts and 2 CC (2016)	Yes: 64 districts, 2 cc and 3 disaster prone	Geo-coded digital small-area maps were produced for 4 disaster-prone districts (Bhola, Barguna, Potuakhali and Jhalokathi. In addition, BBS has produced small area atlases for 64 districts and 2 City Corporation.

		districts	
Sub-output indicator 4.1.3: Number of national population databases that facilitate mapping of socioeconomic inequalities and demographic disparities accessible by users through web-based platforms	3 (2016)	9 (2020)	Same as CPD Output indicator 4.1.3
Sub-output indicator 4.1.4			
1) A functional GIS platform in place	No (2016)	Yes: The platform is active and has regular activities	A functional and user-friendly GIS platform is in place. For the first time in the country, geo-reference data set was prepared.
2) Number of government agencies using GIS for analyses of population data	0 (2016)	8 (2020)	Nine (9) government and non-government agencies are using GIS for analyses of population data: 1) Bangladesh Bureau of Statistics (BBS); 2) Planning Commission; 3) Directorate General of Health Services; 4) Ministry of Education;5) Ministry of Agriculture, 6) Local Government Engineering Department 7) Bangladesh Institute of Development Studies (BIDS), 8) National Institute of Population Research and Training (NIPORT); and 9) four Public Universities (Dhaka University, Jagannath University, Chittagong University, and Jahinnagar University).
***Output 4.2*: the Increased commitment of policy makers and programme managers to advance the ICPD beyond 2014 and the post-2015 development agenda (SDGs)**			
Indicators	**Baseline**	**Target**	**Performance as of June 2019**
Indicator: Percentage point increase of the annual government budget for health, adolescents and youth, and gender programmes	**Health;** **Youth** investment; **Gender;**	Target: TBD	This information not available yet.
***Sub-output 4.2.1** Evidence on P&D is generated to support policy formulation*			
1) Number of analyses based on census and other key population surveys produced	0 (2016)	4 (2020)	3 (1. Demographic Profiling and Needs Assessment of Maternal and Child Health (MCH) Care for the Rohingya Refugee Population in Cox's Bazar, Bangladesh; 2. Exploring Gender-Biased Sex Selection(GBSS) in Bangladesh: A Review of the Situation; 3) A Population Situation Analysis (PSA) to provide reliable data and evidence-based arguments to influence the UN inter-agency process of the CCA to ensure that RH and Population Dynamics are integrated into the priorities of the upcoming UNDAF)
2) Number of advocacy materials produced and used for parliament/government officials using results of in-depth secondary analyses	0 (2016)	8 (2020)	Advocacy material titled "Changing Population Age Structure and its Implications for Development" is produced and has been disseminated widely. This material was used as in input to sensitize and build the capacity of policy makers, high level Government officials and other Relevant officials/experts on how population age structure is being changed over the period of time, what would be the shape in future and what would be its implications for socioeconomic development focusing on planning perspective, which needs to be addressed in the development agenda and 8th Five Year Plan (2021-2025). The following keynote papers (a writeup of 20/30 pages each) were produced and used of policy dialogues, round table discussions. These papers were produced by different experts based on secondary data, like – census, demographic surveys and other study reports.

			-Demographic Transition Towards Elderly: Challenges to Achieve SDGs. -Handling of Population Issues in the Development Agenda and the 8th Five Year Plan in Bangladesh -Necessity and Integration of Population and Development Issues into Plan and Policies in Bangladesh -Child Marriage: A challenge for development- it is socio-economic impacts -Effective use of Population Resource in Bangladesh for Inclusive Economic Growth and Income Distribution: An Application of National Transfer Accounts (NTA) -Trend Analysis of Dependent Population and It is Socio-economic Welfare Implications of Managing them in the 21st Century -Trends and Patterns of Age-specific Fertility Rates, Adolescent Pregnancy and its Implication on Socioeconomic Development for Bangladesh
Sub-output 4.2.2 *Increased knowledge of policy- and decision-makers on P&D issues*			
1) Number of Parliament Sessions where MPs spoke in favour of addressing P&D issues in areas of reproductive health and rights, A&Y development and gender equality	3 (2016)	9 (2020)	Five parliament sessions in 2017, 2018 and 2019 and topics related below have been addressed. (A&Y issues, Child Marriage, Maternal Mortality, ICPD sensitization, Demographic Dividend, Ageing, VAW). - Technical support provided to formulate bylaws/rules of the Child Marriage Restraint Act, 2017 by the BAPPD sub-committee on Eliminate Child marriage and Prevent GBV." - Recommendations provided to MoWCA to promote education as a means to prevent child marriage and empowering girls by the above committee and adopted the decision for MoWCA to work with MoE to introduce 12 compulsory class education for poor female students to prevent child marriage. - BAPPD sensitized policy makers through policy dialogue on Maternal Health Protection, and problems and prospects of Family Planning. - produced advocacy materials on eliminating child marriage and population ageing for mass awareness by parliamentarians in their constituencies. - Maternal Health Protection Bill drafted and handed over to Hon'ble Health and Family Welfare Minister to initiate the process enacting the Bill as a Law - Youth Policy
2) Number of national and sectoral plans and strategies that addresses issues of the ICPD agenda	0 (2016);	3 (2020)	1 ("Rules" of Elimination of Child Marriage Act, 2017)
Sub-(sub) output 4.2.2.1: An experts' forum serves as a platform to promote ICPD agenda to policy- and decision-makers			
1) Number of sectoral plans and strategies that were discussed at an expert forum for the integration of ICPD agenda	0 (2016)	4 (2020)	1 (8th Five Year Plan of Bangladesh)
2) Number of options paper/press release/meeting reports/policy paper produced from a UNFPA-supported P&D experts' forum	0 (2016)	6 (2020)	6 Population expert group is formed under GED. It consists of 20 members out of which 18 are prominent demographers. - GED organized three policy dialogues on **''Child Marriage: A challenge for development-its socio-economic impacts"** and **"Trend Analysis of**

			Dependent Population and Socio-economic Welfare Implications of Managing them in the 21st Century" to increase the understanding of policy makers, high-level government officials and national experts on population development linkage promoting SDGs. - In addition to the above, GED produced thematic papers in collaboration with Expert Committees supported by UNFPA (''**Maternal and Neonatal Health in Bangladesh: a critical look at policy, programme and challenges to achieve SDGs'', "Effective use of Human resource in Bangladesh for Inclusive Economic Growth and Income Distribution: An Application of National Transfer Accounts'',** and ''**Handling of Population Issues in the Development Agenda and the 8th FYP in Bangladesh'', "Necessity and Integration of PD issues into Plan and Policies of Bangladesh''**. - Three of the above thematic papers were discussed by GED in Expert Committee meetings to understand and identify critical issues that should be incorporated into the 8th FYP.
Sub-(sub) output 4.2.2.2: P&D issues adopted as a regular agenda by Parliamentary Standing Committees.			
1) Number of recommendations/ advices on P&D issues given to relevant ministries by the Parliamentary Standing Committees (PSCs);	0 (2016)	3 (2020)	Four recommendations were provided for the Ministry of Hleath and Family Welfare (MoHFW): i) to ensure emergency medical treatment to pregnant mothers; and ii) to ensure availability of emergency medicine to health centers to reduce postpartum hemorrhage and eclampsia; iii) to deploy more midwives at health centres, and iv) to emphasis on family planning programme and appoint FWAs as required.
2) Number of parliamentarians who advocate for ICPD agenda at local and national levels	0 (2016)	14 (2020)	The capacity of BAPPD and its Sub-committees strengthened to reinforce policy advocacy on UNFPA mandated issues, specifically on maternal health and family planning; gender-based violence and child marriage; and demographic dividend and youth. UNFPA supported digital billboard in the parliament to disseminate messages and sensitise the parliamentarians. "why child marriage is harmful", prevalence on GBV, the prevalence of maternal mortality, and a documentary on Child Marriage telecast through parliament TV for all to see. Members of parliament had advocated for the elimination of child marriage, youth development and reduction of maternal mortality in the parliament sessions in 2018 and and 2019 in the Budget Session. 13 MPs had spoken on ICPD agendas at the local level meetings with community people organized by the parliament secretariat with the support of UNFPA. In addition, nine district administrators had discussed child marriage issues in the regional meetings and recommended initiating the process for preparing a bill on maternal health protection to reduce maternal mortality.
Sub-output 4.2.3: *Increased awareness of the local level policy- and decision-makers (at a district level and below) and civil society on P&D issues*			

Indicator: Number of districts where local level committees made decisions/ recommendations on issues relevant to ICPD agenda	Baseline: 0 (2016);	Target: 19 (2020)	Due to Sub-committees' intervention, Administrations of 20 districts officially had taken activities which strengthened the social movement against child marriage and reduced maternal mortality; formed community and student committees; organized discussion meetings with stakeholders including marriage registrars, social and religious leaders; built capacity of locally elected public representatives; organized motivational campaigns; held accountable Teachers and Parents; strengthened monitoring systems; activate community clinics and ensure commodities at health centres; etc. Besides, local level Administration included stop child marriage and promoting maternal health agenda in the district and upazila levels monthly coordination meetings, ensured discussions, continuous followed up and regular monitoring. All his efforts yielded significant reduction of both maternal mortality and child marriage and consequently, the local admiration declared as child marriage free upazilas and districts.

Source: UNFPA Bangladesh Country Programme

Annex D-2: P&D Achievements (2017- June 2019)

***A census master plan for Population and Housing Census 2021 developed**:* The Bangladesh Bureau of Statistics (BBS) completed the master plan for 2021 Population and Housing Census in 2018 with UNFPA technical support. This plan was prepared through a consultative process and pre-testing of the questionnaire and methodology at the field level which will be used to conduct the next round of Population and Housing Census using multimodal data collection approach in 2021. The plan will be finalized in 2018 and approved in 2019. Following the master plan, BBS has also developed a detailed project proposal (DPP).

An SDG and 7th Five-Year Plan Monitoring and Evaluation Framework is in place: The General Economics Division (GED) of Bangladesh Planning Commission developed the final draft M&E Framework based on several consultations to identify data sources of SDG indicators, to set multi-year targets and to map ministries responsible for the implementation of specific targets, aligned with 7th Five Year Plan (2016-2020). UNFPA, as an active member of the UN Data Group, played an important role to include UNFPA mandated indicators in the framework. UNFPA also provided technical support to GED through their meetings with UN Data Group and written comments to improve the framework. UNFPA is working with its government Implementation Partners to establish a comprehensive data collection and management mechanism to monitor and report on their relevant SDG indicators. As a part of it, a day-long interagency coordination workshop on SDG monitoring and reporting was organized on 28 December by Bangladesh Bureau of Statistics (BBS) with UNFPA support where representatives from 17 ministries participated. The participants were oriented on respective SDG indicators for which they are responsible and jointly reviewed data sources and data availability with BBS.

Dissemination of Bangladesh population and housing census and survey micro-data through REDATAM: In 2015, one of the most significant achievements of the UNFPA supported Census Project was that the BBS had made the micro census data available online for ease of access for the general public, for the first time in history. During the 9th CP, BBS uploaded and disseminated 6 new datasets through REDATAM web portal bringing a total of 9 datasets uploaded so far. Availability of demographic data by age and sex, location and poverty have thus increased among the data users for research and planning purposes. This initiative will facilitate online data users regarding the mapping of socioeconomic and demographic inequalities.

UNFPA-supported P&D Experts forum is functional: A population expert group has been formed under the General Economics Division (GED) of Bangladesh Planning Commission with UNFPA support, in order to lead knowledge generation, sensitization and integration of population dynamics in government development programmes, specifically in national and sectoral plans. GED leads the policy level activities of the Government and has a coordination role among sectoral ministries and development partners regarding development issues. The Expert Group is comprised of 24 experts in population and development working in Bangladesh.

A functional GIS platform in place: A Geographic Information System (GIS) Platform established by the Bangladesh Bureau of Statistics (BBS) with UNFPA support in 2016 was more useful and active throughout the year in 2018. A website of the platform was developed to share relevant GIS data of all member organisations. Presently, nine agencies are active to discuss and exchange GIS information and enhanced usage of geospatial data in programming and decision-making. Bangladesh Bureau of Statistics (BBS), with UNFPA support, prepared a geo-coded digital geographical information systems (GIS) map of five disaster-prone districts with information related to available facilities such as education institutions, health facilities and cyclone shelters where disaster-affected people can take shelter. Both the districts are located in the coastal belt and most disaster-prone districts in Bangladesh. The map also included population data based on the 2011 Census and geo-codes of all administrative units of the district.

Harmonisation of major demographic surveys in Bangladesh initiated: Bangladesh Bureau of Statistics (BBS) with UNFPA support prepared a comprehensive position paper on the harmonisation of major demographic studies in the country. The position paper also provided with cost analysis, including cost-saving mechanism. A draft roadmap for harmonising the major demographic surveys has also been prepared by BBS. A very high-level Steering Committee headed by the Secretary, Statistics and Informatics Division (SID) and a Technical Committee chaired by an Additional Secretary was formed to take forward this harmonisation initiative.

Gender-biased sex selection (GBSS) study finalized: A comprehensive analyses based on population surveys including Bangladesh Demographic and Health Survey (BDHS), Multiple Indicator Cluster Survey (MICS), Sample Vital Registration System (SVRS) and Bangladesh Population and Housing Census conducted together with Department of Population Sciences, Dhaka University on the Sex Ratio at Birth (SRB) was finalized and the findings disseminated involving academia, government, NGOs, other professionals and students. The study found no specific, conclusive evidence of GBSS in Bangladesh based on the secondary data review.

Rohingya need assessment survey completed and results disseminated: A cross-sectional study was conducted in Cox's Bazar through International Centre for Diarrhoeal Disease Research, Bangladesh

(icddr,b) to determine the health needs, identification of some accurate estimates and demographic profiling of Rohingya population living in Bangladesh. The study findings were shared with UNFPA staff and other UN Agencies in Cox's Bazar. The report is now being used as an essential element in programme planning for Rohingya people in Cox's Bazar.

Use of administrative data for SDG monitoring and reporting: General Economic Division (GED) of Planning Commission strengthened the capacity of Sustainable Development Goals (SDG) focal persons from 9 relevant ministries and 11 United Nations Data Group members on administrative data collection and reporting of SDGs indicators particularly 16 indicators under UNFPA commitment. For this, two batches of training workshops were organized with ministries' SDGs focal persons who contributed to increasing the level of participants' understanding on the availability of data sources, metadata of indicators, disaggregation of data and reporting of the indicators. The SDG Cell at the Bangladesh Bureau of Statistics (BBS) was supported to harmonise SDGs Action Plan of respective Ministries/Divisions in line with the core principles of SDGs. This will help BBS report on relevant SDG indicators using the Ministries' administrative data.

Evidence and recommendations for the 8th Five-Year Plan by Population Expert Group/Committee (PEC) on Population and Development: The General Economic Division (GED) of Planning Commission produced several thematic papers in collaboration with Expert Group*/Committee* supported by UNFPA. The documents include - 1) Analysis of the dependent population and its socioeconomic welfare implications in Bangladesh in the 21st Century; 2) Maternal and Neonatal Health in Bangladesh: a critical look at policy, program and challenges to achieve Sustainable Development Goals; 3) Effective use of Human Resource in Bangladesh for Inclusive Economic Growth and Income Distribution: An Application of National Transfer Accounts. GED also discussed the thematic papers in two Expert Group*/Committee* meetings to understand and identify the critical issues of the thematic documents for incorporation into the 8th Five-Year Plan (2021-2025) of Bangladesh. Finally, GED has agreed to use these documents as inputs during the formulation of the 8th Five Year Plan in 2019 along with national plans and policies.

Successful advocacy with Bangladesh Parliament for policy changes: The Bangladesh Association of Parliamentarians on Population and Development (BAPPD) was formed previously under the chairmanship of the Speaker of the Parliament. UNFPA Bangladesh was prosperous in advocacy and policy discussions with BAPPD, resulting in crucial policy level changes.

Firstly, for the first time in the Parliamentary history, a Bill titled '**Maternal Health Protection Bill'** has been drafted by a parliamentary committee assisted by a law review committee of the Parliament headed by a Joint Secretary and technical assistance provided by UNFPA. To prepare the Bill, several consultation workshops/meetings were organized at a divisional and national level by the Committee with the technical and financial support from UNFPA. The Committee also organised policy dialogues/meetings to sensitise and solicit support from the Member of Parliament (MP). The Bill will contribute to reducing maternal mortality and morbidity in the country by ensuring emergency medical services, notifying maternal death properly and ensuring accountability of service providers and family members.

Secondly, after passing the Child Marriage Restraint Act 2017, the Eliminate Child Marriage and Prevent Gender-based Sub-committee, BAPPD, in consultation with UNFPA, worked with the Standing Committee on the Ministry of Women and Children Affairs (MoWCA) and provided substantive technical support to the Committee through the Law Review Committee, formed under the SPCPD project, to formulate Bylaws/Rules of the Child Marriage Restraint Act, 2017. UNFPA facilitated an Inter-Ministerial meeting at the Bangladesh Parliament organised by the Ministry of Women and Child Affairs (MoCA),

and a series of consultations with technical assistance from the Law Review Committee for reviewing the Bylaws/Rules where a paper was presented with specific recommendations from UNFPA.

Parliamentarians are advocating for ICPD agenda at local and national levels: Because of UNFPA's advocacy towards Members of Parliament (MP) on the ICPD agenda, two MPs actively advocated for the elimination of child marriage, youth development and reduction of maternal mortality in the parliament sessions in 2018. Furthermore, 13 (thirteen) MPs spoke on ICPD agendas at the local level meetings with community people organised by the Parliament Secretariat with the support of UNFPA where over 22,000 people including local elected representative taken part. During the reporting period, nine district administrations discussed child marriage issues in the regional meetings and recommended initiating the process for preparing a bill on maternal health protection to reduce maternal mortality. Based on the recommendations, a bill titled '**Maternal Health Protection Bill'** drafted with UNFPA technical support in 2018.

Population surveys included appropriate methodologies with UNFPA support:

UNFPA, in partnership with International Centre for Diarrheal Disease Research, Bangladesh (icddr,b) has started the implementation of a population-based survey among the Rohingya Refugees in December 2017. The survey methodology and data collection instruments of the survey were designed with support from UNFPA. The purpose of the survey is to ascertain their demographic profiles in order to explore the health needs and factual estimates of the prevalence of pregnant women, lactating mothers and age-sex distribution of the population to help the government and humanitarian actors with the planning of their responses to Rohingya refugee crisis. Furthermore, as a result of successful UNFPA's advocacy with UNICEF MICS Team, the morbidity module has been included in the sixth round of Multiple Indicators Cluster Surveys (MICS) 2018, led by UNICEF and BBS. UNFPA designed the methodology and questionnaire of the new module. The module is included to capture some specific indicators of high significance to UNFPA and other stakeholders related to maternal health. Data collection will begin from May/June of 2018 and findings will be available by the end of 2018.

Parliamentarians are advocating for ICPD agenda at local and national levels:

As a result of UNFPA's advocacy towards Members of Parliament (MP) on the ICPD agenda, two MPs actively advocated for the elimination of child marriage, youth development and reduction of maternal mortality in the 16th and 17th session of the 10th Parliament in 2017. Furthermore, eight MPs spoke on ICPD agendas at the local level meetings with community people organised by the Parliament Secretariat with the support of UNFPA. This was possible through engaging MPs, including the Speaker of the Parliament, through different channels and local level consultation meetings at the district and Upazila levels, including distribution of printed evidence-based advocacy materials, a documentary film titled "Stop Child Marriage: A Social Commitment" and other information materials. The documentary features MPs role in creating mass awareness on harmful consequences of child marriage in their respective constituencies and highlighting the importance of social security of girls to complete their education, which was aired on the Parliament TV channel.

Annex D-3 PD Capacity Building Input and Knowledge Products

Several Capacity Development Interventions had been completed under CP9 that are directly linked to planned outputs are:

Diploma course on Population, Reproductive Health and Gender Issues (Pop Science Department, Dhaka University); Certificate course on Gender-Biased Sex Selection and Demographic Dividend in BGD, Training by GED; Policy Dialogue by GED; Orientation on SDG indicators, and Capacity building of Public Representatives (locally elected bodies) to ensure midwifery-led maternal health services, 24/7 maternal health services in all health facilities, reduce gender-based violence and reduce child marriage. National Transfer of Accounts training (application useful for demographic dividend) was partially done and due to lack of funds the programme had to be stopped. Following two tables illustrate the training conducted and knowledge products under Population and Development during the period 2017-June 2019.

Table: D3-1 List of Training/Workshop conducted under PD from 2017- June 2019

Sl No.	Implementing Partner	Title of the training/ workshop	# of Participants	Duration
1.	Dhaka University (DU)	Diploma in Population Sciences 2017	31	October 2017 to January 2018
2.	Dhaka University (DU)	Diploma in Population Sciences 2018	22	September 2018-December 2018
3.	Dhaka University (DU)	Short Certificate Course of GoB Officials on Gender Biased Sex Selection (GBSS) and Population Dynamics	17	10-12 December 2018
4.	Dhaka University (DU)	Short Certificate Course for GoB Officials on Demographic Dividend in Bangladesh: Are We Prepared?	22	12 – 14 March 2019
5.	General Economics Division (GED)	Knowledge sharing workshop on Integration of Population and Development issues into Plans and Policies	30	27 December 2017
6.	General Economics Division (GED)	Knowledge sharing workshop on Integration of Adolescent Reproductive Health Issues, Maternal Mortality/Morbidity and Family Planning Challenges: Policies, Programmes and Current situation in Bangladesh	40	13 Sept. 2018
7.	General Economics Division (GED)	Workshop on SDGs Indicators	45	19th March. 2018
8.	General Economics Division (GED)	Workshop on SDGs Indicators	40	18 Dec. 2018
9.	General Economics Division (GED)	Training on National Transfer Account (NTA)	21	9-14 May 2018
10.	General Economics Division (GED)	Training on National Transfer Account (NTA)	22	19-24 Sept. 2018

11.	General Economics Division (GED)	Knowledge sharing workshop on Maternal and Neonatal Health in Bangladesh: A Critical look for Achieving SDGs	40	26 December 2018
12.	Bangladesh Bureau of Statistics (BBS	Workshop on SDGs	50	28 December 2017
13.	Bangladesh Bureau of Statistics (BBS	Workshop on Harmonization of Demographic and Social Development Statistics	45	31 March 2018
14.	Bangladesh Bureau of Statistics (BBS	Workshop on harmonization of Demographic and Social Development Statistics	42	8 April 2018
15.	Bangladesh Bureau of Statistics (BBS)	Consultation Workshop on Population and Housing Census 2021	25	7 May 2018
16.	Bangladesh Bureau of Statistics (BBS)	Workshop on Methodological Issues on 2021 Census	20	10 June 2018
17.	Bangladesh Bureau of Statistics (BBS)	Consultation Workshop on Population and Housing Census 2021	85	26 September 2018
18.	Bangladesh Bureau of Statistics (BBS)	Workshop on Population and Housing Census 2021: Prospect and Challenges	60	5 December 2018
19.	General Economics Division (GED)	Knowledge sharing workshop on Changing Population of Age Structure and its Implications for Development	40	24 March 2019

Table:D3-2 Knowledge Products and Status (under Population & Development)

Research / Plan/ Strategy Paper			
1.	Master Plan for 2021 Population and Housing Census	BBS	Completed
2.	The situation of gender-biased sex selection (GBSS) in Bangladesh	Dhaka Uni. (DU)	Completed, Joint activity with Gender Unit
3.	Understanding the drivers of GBSS in Bangladesh	DU	Work in progress, Joint activity with Gender Unit
Keynote Paper / Position Paper / Policy Brief			
1.	Demographic Transition Towards Elderly: Challenges to Achieve SDGs.	Parliament	Finalized and used for Policy Dialogue
2.	Handling of Population Issues in the Development Agenda and the 8th Five Year Plan in Bangladesh	GED	Finalized and used for Policy Dialogue
3.	Necessity and Integration of Population and Development Issues into Plan and Policies in Bangladesh	GED	Finalized and used for Policy Dialogue
4.	Child Marriage: A challenge for development- it is socio-economic impacts	GED	Finalized and used for Policy Dialogue
5.	Effective use of Population Resource in Bangladesh for Inclusive Economic Growth and Income Distribution: An Application of National Transfer Accounts (NTA)	GED	Finalized and used for Population Expert Committee discussion
6.	Trend Analysis of Dependent Population and It is Socio-economic Welfare Implications of Managing them in the 21st Century	GED	Finalized and used for Policy Dialogue
7.	Trends and Patterns of Age-specific Fertility Rates, Adolescent Pregnancy and its Implication on	GED	Finalized and used for Policy Dialogue

	Socioeconomic Development for Bangladesh		
Surveys / Assessment			
1.	Demographic Profiling and Needs Assessment of Maternal and Child Health (MCH) Care for the Rohingya Refugee Population in Cox's Bazar, B'desh.	UNFPA Country Office	Joint activity with SRH Unit (Used in Cox's Bazar)
2.	Child marriage study	DU	Joint activity with A&Y Unit
3.	Multiple Indicator Cluster Survey (MICS)	Unicef/ BBS	UNFPA incorporated a new section on maternal morbidity and provided support to BBS for quality assurance of data
Knowledge Products			
1.	Small Area ATLAS of the disaster-prone of six districts with information related to available facilities where disaster-affected people can take shelter.	BBS	Published
2.	Documentary film titled "Stop Child Marriage: A Social Commitment"	Parliament	Completed
3.	Leaflet on three issues and disseminated	Parliament	Published
4.	Documentation of best practice of Parliament project	Parliament	Published

ANNEX E: Relevance Criteria

Additional Information on Findings under Relevance (4.1) criteria (due to the page limit of CPE, the detailed information under the four outcome areas could not be included in the main report and this information will be useful to UNFPA CO and other interested parties)

4.1.1 Sexual and Reproductive Health & Rights: Relevance

Summary of findings:

-The SRHR component focused on support to the GOB objectives in SRHR related policies and strategies and is as such aligned with the GOB priorities. The UNFPA SRHR programme has, moreover, contributed to the development of strategies and policies in the previous and present programme cycle and in this way contributed to GOB priorities.

-Selection of UNFPA focus districts has been guided by social development criteria, with selection of upazilas guided by issues of need and feasibility. Moreover, the programme has paid attention to the targeting of specifically vulnerable and marginalized groups.

-Various parts of the SRHR programme have been informed by need- and other types of assessments.

-The SRHR programme component, with its focus on MNH, FP and integrated SRH services (such as fistula, cervical cancer and HIV/STI) with equity, is in line with the UNFPA strategic plan

-In the humanitarian programme in Cox's Bazar, UNFPA's response was informed by its existing work with Rohingya refugees, before the main influx in August 2017. Moreover, a joint situation analysis of UN agencies with GOB informed programming as well as other assessments made. With the programme, moreover, already targeting the local population of Cox's Bazar, UNFPA was able to reinforce its programme in host communities and balance support to local communities and refugees.

-The UNDAF was informed by a common country analysis carried out in 2015 by the UNCT. It reflects the

UNFPA interests in terms of inclusion of MNH, Family Planning and treatment of people living with HIV.

SRHR Development Programme

The UNFPA country programme is in line with GOB strategies and policies and has contributed to the development of many of those related to SRHR. The country programme is in line with the GOB seventh five-year plan, 2016-2020, in which GOB aims to create the conditions under which the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health.[17] Much of the attention in the present programme cycle has been on getting systemic change in terms of availability of quality SRH services, with a focus on midwives. There has been less focus on the demand for and access to services, with the assumption that well-functioning systems will ultimately lead to increased patient flow, though with the recognition that access is not always achieved due to a variety of cultural, religious and financial barriers.

The UNFPA programme has been in line with the GOB strategic directions, focusing on reducing MMR through facility delivery and skilled-birth attendants (SBAs); with the note that SBAs have been adapted to a focus on midwives, including registered as well as certified midwives.[18] In this regard, UNFPA provided support to the development of the National Midwifery Policy, which focuses on the quality of maternal and newborn care in order to further reduce the maternal and newborn mortality in Bangladesh. The policy aims to create a positive environment for midwifery governance and practice and to promote midwifery education and accreditation and quality of midwifery care, in a way in which it becomes integrated with other components of sexual and reproductive health care in hospitals and communities. The policy promotes a competent midwifery workforce, capable to lead reproductive, pregnancy, birth and new-born care in line with international standards and includes details on the development of midwifery education, training, accreditation and services.[19]

UNFPA supported the development of the strategies and action plans to implement the five-year plan and the health related strategy, including the Eclampsia and Postpartum Hemorrhage Action plan, the Cervical Cancer Strategy and the Fistula strategy. UNFPA has been implementing programmes through the government as well as NGOs to meet national goals and targets set out in these strategic documents. Moreover, the UNFPA programme with its focus on access for adolescents and youth to SRH information and services and the need for SRH services aimed at this group to be adolescent friendly is in line with the National Adolescent Health Strategy. For details on the strategies and plans concerned see Annex A-1.

The programme focus on reducing the unmet need for family planning, the support to the use of long term methods and the stimulation of the use of contraceptives by married adolescents, aiming to delay pregnancy and ensure that every pregnancy is wanted, and to improve postpartum family planning uptake are in line with the GOB policies concerned.

[17] General Economics Division, Planning Commission, Government of the People's Republic of Bangladesh, 7th Five Year Plan FY2016 – FY2020, Accelerating Growth, Empowering Citizens, Dhaka, December 2015.
[18] There are two routes to become a midwife:1) direct entry 3 year diploma course for midwives, more colloquially called as 'registered midwives', 2) for those who had 4 years of 'nursing and midwifery' education, 6 months top up of missing competencies made them a midwife, they are also referred to as 'certified midwife'.
[19] Directorate General of Nursing and Midwifery, MoH and Family Welfare, National Policy Guideline for Midwives, 2018.

At the sub-national level, the SRHR outcome area of the UNFPA programme focused at nineteen districts. These districts were identified based on a number of criteria, including contraceptive prevalence rate, unmet need for family planning, neonatal mortality rate, maternal deaths, antenatal care visits, and delivery by skilled birth attendants, prevalence of child marriage and HIV and GBV related criteria.[20] Moreover, UNFPA particularly focused on providing services to vulnerable and marginalized groups and underserved areas, including tea garden workers in Moulvibazar, ethnic communities in the Chittagong Hill Tracts and communities in vulnerable geographical areas, including haor, char and coastal areas. Particularly vulnerable groups also included survivors of sexual and gender based violence, fistula patients and brothel-based sex workers, who were targeted in the SRHR programme.

Within the nineteen focus districts, a total of 82 upazilas were selected from the 200 upazilas that made up the 19 districts, i.e. 41 percent of all upazilas in the districts. Selection of upazilas was based on a set of characteristics identified for all the upazilas in the 19 districts. When reviewing the selection, it appears that upazilas with health complexes that could cover women from multiple upazilas were prioritized, while those upazilas where women would mostly seek health services in nearby upazila health complexes or the nearby district hospital, were not selected. Also accessibility of health facilities played a role. In addition, focus has been on upazilas at a mid-range of capacity, with part of the human resources and SRH services in place but with gaps concerned. Upazilas with most capacities lacking were not selected. This goes for example for Badshiganj, Madarganj and Melandaha in Jamalpur district, for which the information sheet records the following characteristics: *"1. Poor level of health services available; 2.Less patients come for the services; 3.HR gaps (less no. of doctors are currently deployed in these UHCs) 4. No CEmONC services available".* Patharghata upazila in Barishal district is another example of an upazila that was not selected, where details include: *"1. Poor road communications; 2. Very less no. of normal deliveries conducted; 3. HR gaps; 4. No midwives deployed".*[21]Where upazila health complexes were not selected due to lack of easy access or severe limitations in human resource capacities, a limited number of union health facilities were selected and supported, in this way enhancing access to health facilities for remote populations.

Several parts of the programme were informed by needs and other thematic assessments, in order to inform programming. The MNH component of the SRHR outcome area was informed by an assessment of the key factors related to the level of MMR in Bangladesh and reasons for its plateauing in recent years. SRHR programming remained dynamic as approaches for interventions were updated with emerging evidence and reality in the ground; for example, the previous approach to combat fistula was centered on the fact that there are approximately 70,000 fistula cases in the country (Ref: Engender Health & UNFPA assessment 2003). But the BMMS 2016 estimated the presence only 20,000 fistula cases. This shifted programme approach from widespread scale up of services to focused identification of women with fistula and rigorous follow up for surgery and reintegration.

UNDAF continues to contribute to GOB priorities and does include mandate areas of UNFPA, including MNH, FP, adolescent sexual and reproductive health, health sector response to gender based violence

[20]UNFPA District Selection Dataset-short (Excel spreadsheet).
[21]UNFPA Upazila Selection Criteria SRHR April 3, 2017 (Excel Spreadsheet).

and diagnosis and treatment of people living with HIV. Moreover, it pays attention to removal of discrimination enshrined in laws as well as enabling factors for programme implementation, including overall health expenditure as well as gender budget, including aspects concerned in the UNDAF results framework.

SRHR Humanitarian Programme in Cox's Bazar and other areas

Before the main influx of Rohingya refugees in August 2017, UNFPA had been working with Rohingyas who had been fleeing from Myanmar and crossed the border with Bangladesh, taking refuge in Cox's Bazar. UNFPA responded with the posting of midwives in the existing government and NGO health facilities, which meant that pregnant women could receive SRHR services, including lifesaving EmONC. Response was informed by a rapid assessment of existing facilities in the area of Cox's Bazar. Moreover, in December 2017, UNFPA started a population-based survey among the Rohingya refugees in partnership with the International Centre for Diarrheal Disease Research (ICDDR) of Bangladesh. The survey enabled to ascertain the demographic profiles of the refugee communities in order to explore the health needs and factual estimates of prevalence of pregnant women, lactating mothers and age-sex distribution of the population in order to support the government and humanitarian actors with relevant data to inform the planning of their responses.[22] Moreover, the response of UNFPA in host communities was informed by UNFPA's SRHR initiatives that existed before the major influx of Rohingya refugees in August 2017.

In addition to the response to the large influx of Rohingya refugees after August 2017, in that same year UNFPA responded to four other emergencies, including the situation of Rohingya refugees existing in early 2017, cyclone Mora in June, and landslides in CHT and flooding in Sylhet division.

4.1.2 Adolescents and Youth: Relevance

Summary of findings: The A&Y programme is fully aligned with UNDAF and government priorities as reflected in the Seventh Five Year Plan (2016-2020), Agenda 2030 including the SDGs to address the unmet ARSH needs of vulnerable adolescent groups, as well as commitment to End Child Marriage and Gender based Violence. Evidence indicates that the Adolescent and Youth programme interventions are highly relevant for the context of Bangladesh where 35 percent of the population is adolescents and youth. The programme components are tailored to address the critical needs of adolescents and youth, especially young girls as a vulnerable category of the population due to their lack of access to information on sexual and reproductive health, quality ASRH services and vulnerability to violence. The programme targeted to build the knowledge base by introducing Standardized Life Skills Education (LSE), through school interventions, discussion sessions on gender equality to address violence against girls and women. A&Y programme also includes a comprehensive programme on ending child marriage, along with providing technical support to develop policy frameworks in favour of adolescents and youth.

Alignment with government priorities& UNDAF: The Adolescent and Youth (A&Y) Programme recognizes adolescents and youth as a vulnerable category, and addresses adolescent sexual and reproductive

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

health (ASRH), violence against young girls, and child marriage which are critical areas of concern for young girls and boys in the country. The programme is fully aligned with UNDAF and government priorities as reflected in the Seventh Five Year Plan (2016-2020), Agenda 2030 including the SDGs.

Implementing partners mentioned the interventions as highly relevant since they are addressing a major critical area of concern for adolescent girls and boys. The rationale for this includes but is not limited to:

- As expressed in the UNDAF, adolescents in the poorest households have the highest unmet ASRH needs (as measured in infant and child mortality rates, and child morbidity), as a result of inadequate access to and poor quality of antenatal, prenatal, child and maternal health services.
- The high rate of child marriage and gender-based violence in program districts exacerbates pregnancy related complications, psychological consequences and mental health problems.
- The adolescents and youth are vulnerable to stigma, taboo and misconceptions regarding ASHR related issues which causes an extraordinary amount of stress among the young population. Life Skills Education supported by UNFPA is helping boys and girls to gain critical knowledge and understanding of ASRH information and available services in their locality.

Addresses the needs of vulnerable populations: Young people in Bangladesh, both in urban and rural programme districts, have been lacking reliable sources for ASRH information which has been made available by UNFPA A&Y interventions. The A&Y programme addresses adolescent sexual and reproductive health (ASRH) needs in collaboration with government partners – the Ministry of Education, Directorate of Secondary and Higher Education, the National Curriculum and Textbook Board, the Ministry of Women and Children Affairs, the National Skills Development Authority and the Department of Youth Development and the Directorate General of Family Planning. UNFPA supported government partners to improve their capacity to implement evidence-based policies, strategies and services for adolescents and youth including sexual and reproductive health and rights, to facilitate the delivery of gender responsive life skills education, and the prevention of child marriage.

4.1.3 Gender Equality & Women's Empowerment (GEWE): Relevance

Summary of findings: The 9th Country Program interventions of the gender component addresses vulnerable groups especially women and children in hard to reach areas and from vulnerable communities. The program is in line with national priorities as outlined in the National Action Plan to Prevent Violence Against Women (2013 to 2025, the new time frame of the revised version is 2018-2030), Seventh Five Year Plan (SFYP), and UN Declaration of SDGs. The programs are in line with the principles of UNFPA strategic principles and UNDAF outcome no.1 "All people have equal rights, access and opportunities."
The 9th Country Program of UNFPA also dealt with humanitarian responses arising from 5 emergencies including nationwide floods, landslides in Rangamati, CHT, Cyclone Mora and the influx of Rohingya refugees keeping in mind its mandate as global leader of GBV and signature interventions focused on prevention and response to GBV in Emergencies.

The CP9 interventions of the gender component was proposed to be 8.1 million USD, with 7.6 from regular resources and 0.5 million USD from other resources.[23] The total for GEWE constitutes 15.40 % of

[23] Proposed Indicative UNFPA assistance, UNFPA Country programme document, 2016.

the total assistance for CP9, but almost one third (28.9 %) of regular sources (2nd in position to SRHR which was 35.74%) is allocated for gender component. The gender component addresses the various needs of the population including vulnerable and marginalized groups as women and children are considered to be a core vulnerable group in accordance with the gender analysis that took place in the design of the CP9.[24] In addition to that, women in hard to reach areas, minority ethnic and religious communities, are given special attention, as observed during the field visits to remote districts and humanitarian sector. Keeping in line with government priorities as explicated in the National Action Plan to Prevent Violence Against Women (2013 to 2025, the new time frame of the revised version is 2018-2030) as well as the UN Declaration of Sustainable Development Goals (SDGs),[25] specifically Goal Five on women's equal participation and opportunities for leadership of women, and UNFPA strategic principles and UNDAF Ooutcome no. 1: All people have equal rights, the gender programme stays relevant to the government as well as global priorities.

During the period of CP9, Bangladesh had to face the rapid influx of Rohingyas fleeing military repression in the Rakhine state of Myanmar thus creating grounds for a massive humanitarian response in the south eastern district of Cox's Bazaar, Bangladesh. UNFPA responded to the crisis through its mandate as the global leader for SGBV. It took the role of coordinator of GBV, a sub sector of protection issues in the International Sectoral Coordination Group. UNFPA has been providing life-saving sexual and reproductive health services supplies and information as well as prevention and response to GBV to support survivors on the path to healing, recovery and empowerment. Signature interventions in this latter aspect has been Women Friendly Space (WFS) through which 106,495 women and girls accessed a safe haven space, in 2018, 59,939[26] women and girls accessed in 2017[27] and also Women Led Community Centers through which around 2000 women and girls participated in skills training serving the needs of the beneficiaries.[28] While UNFPA provided around 100,000 dignity kits, GBVIMS monitoring was conducted in 8 facilities in 4 camps.[29]

4.1.4 Population Dynamics (PD): Relevance

Summary of findings- Aiming at the development of national capacity for policy advocacy and generation of population data for evidence based planning and budgeting, PD programme is designed based on the ICPD POA and is in line with 2030 Agenda for sustainable development, UNDAF (2017-2020), UNFPA SP 2014-2017 and 2017-2021, and 7th FYP of Bangladesh. Taking into consideration the stakeholders' feedback, and a detailed analysis of population data, CP9 selected needy populations (district selection) and addressed key issues identified in 7th FYP.
- Selection of the strategic partners (BBS, GED, Parliamentarians and the academic institution) is highly relevant given the expected CP9 outcomes. However, The National Population Council (NPC) (which is under the MoH) as the highest national body that deals with population issues has not been functioning effectively since 2010 and unless NPC is fully functional, implementation of national population policies may not be effective even if UNFPA assistance stays relevant to the government priorities.

[24] Gender Team, UNFPA CO.
[25] UN, The 2030 Agenda for Sustainable Development, 2015
[26] UNFPA 2018 Annual Report)
[27] UNFPA 2017 Annual Report
[28] UNFPA , Annual report2018, progress and highlights, Dhaka, Bangladesh,p.18
[29] Information received through CO in June post field visit.

- While UNFPA PD programme provided much needed data on various minority groups for planning purposes, it is still not adequate to map the inequalities and disparities. Without targeted data collection and monitoring for evidence based planning for service provision and measuring changes in the marginalized and vulnerable groups could limit the programme relevance to beneficiary needs.
- PD programme outputs, as described under the effectiveness criteria, are clearly linked to priorities identified in the 7th FYP, Country priorities, UNDAF results frame, and National strategies and addresses national development challenges within the capacity of UNFPA.
- Some national development challenges not addressed in CP9 are issues related to ageing and internal and international migration. There are also areas that UNFPA assistance could produce better results if national authorities are in appropriate offices to fully deploy their functions, for example BBS, NPC could be made more functional and stay more relevant to the cause which will help UNFPA to be more effective in its technical assistance.
- Humanitarian response and preparedness programs have made use of the data provided by PD programme adapting and responding to the emerging needs identified in the population data. According to responses to an opinion survey, UNFPA staff as well as a few IPs (convenient sample), almost all agreed that PD programme is highly relevant to the country's development context and is in line with the government strategies and development plans.

Consideration has been given, at the programme design stage itself, to conduct an analysis of population to identify the priority geographic areas and the communities that are hard to reach and needing attention and development assistance. The process of programme area selection is available (ref: Program site selection) and population data were made available for targeted planning. However, data gaps on minority groups exist thus inadequate to map the inequalities and disparities.

Operating as a catalyst, PD support is through the national level IPs (BBS, GED, University, Parliamentarians) addressing policy level development issues. PD's influence to make an impact on macro issues related to the 7th FYP, ICPD POA, SDGs, and other national development challenges[30] are recognized and accepted, by the government, as very relevant. Mode of engagement is mainly via capacity development (CD) advocacy and policy support (AP) and knowledge management (KM).

The following provides a few examples to substantiate how P&D interventions are relevant to the people/programme beneficiaries on the ground (further details can be found in Annex D-2 and under the P&D Effectiveness criteria). Due to the engagement of parliamentary sub-committees, administrations of 20 districts had officially taken steps to strengthen the social movement against child marriage and reduced maternal mortality by forming community and student committees, organizing discussions and meetings with stakeholders including marriage registrars, social and religious leaders, building capacity of locally elected public representatives, activating community clinics and ensuring commodities at health centres etc. to stop child marriage and reduce maternal mortality. To enhance this, local level Administration included stop child marriage and promoting maternal health agenda in the district and upazila levels' monthly coordination meetings, with continuous follow- up and regular monitoring, consequently resulting in the local admiration declaring child marriage free upazilas in those districts. Furthermore, disaggregated data generated by the unit has contributed to gender analysis for planning purposes.

[30] These are explained under the national challenges.

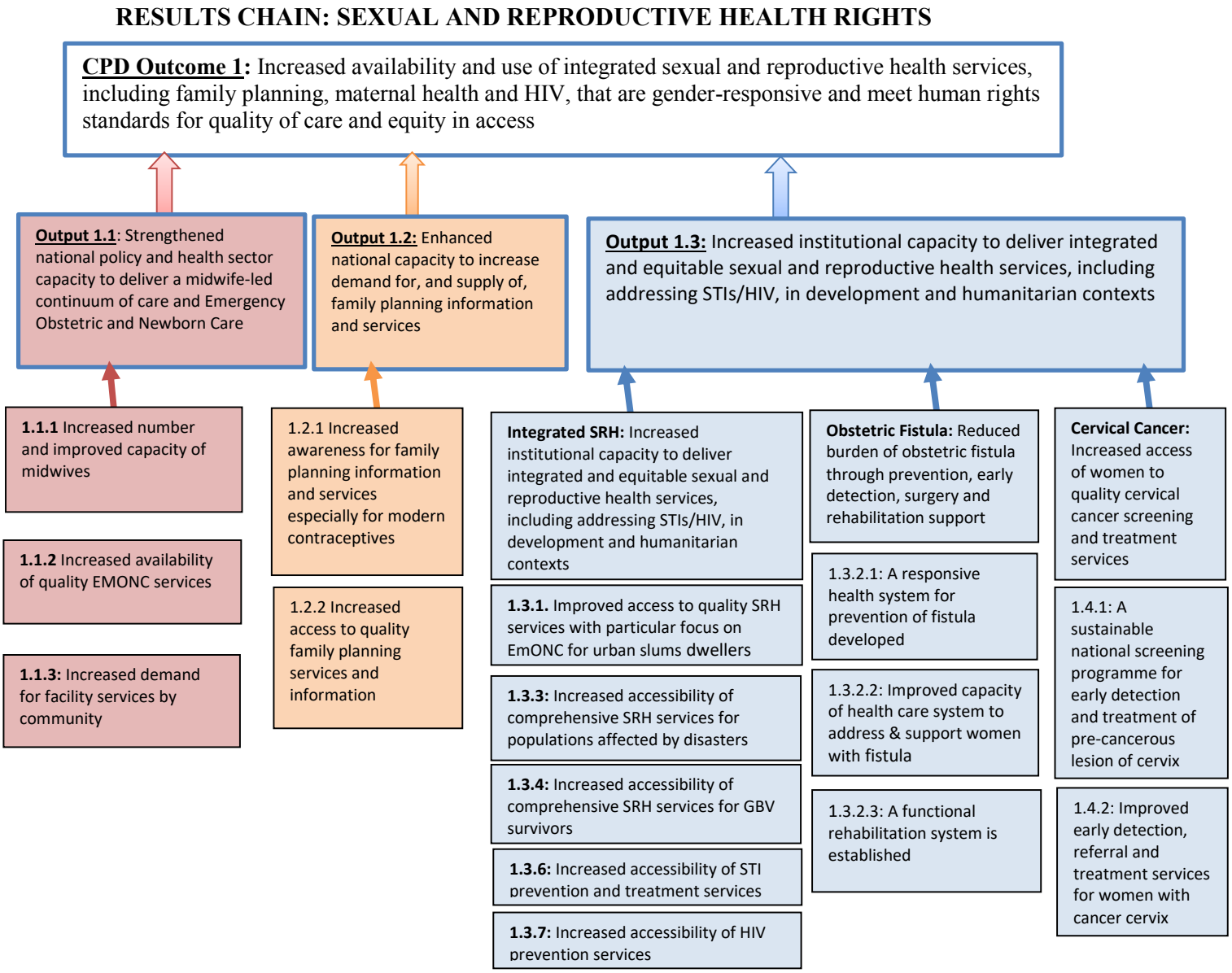
The National Population Council (NPC), according to the country's population policy, the highest national body that deals with population issues, is under the Ministry of Health but has not been functioning effectively since 2010. This has implications for the P&D unit's development agenda. Bringing the Population Section under the Ministry of Planning from the Ministry of Health is still under consideration and UNFPA has been advocating through the P&D Expert Group to mainstream population issues within the Planning Ministry and supporting the various initiatives through GED. Population Expert Group's recommendation was that GED should take the lead on updating or revision of the existing population policy. This issue was brought up by UNFPA and at a Parliamentary discussion a BAPPD sub-committee had discussed how the existing policies can be updated. UNFPA is advocating with an attempt to bring consensus among the policy and law-makers since this would be one of the important areas to work on during the next country programme. However, this is a broader national issue where inter-agency initiatives may be needed. While UNFPA input is relevant, the effectiveness can be diminished if the right authorities are not in right place and not powerful in making appropriate policy decisions.

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

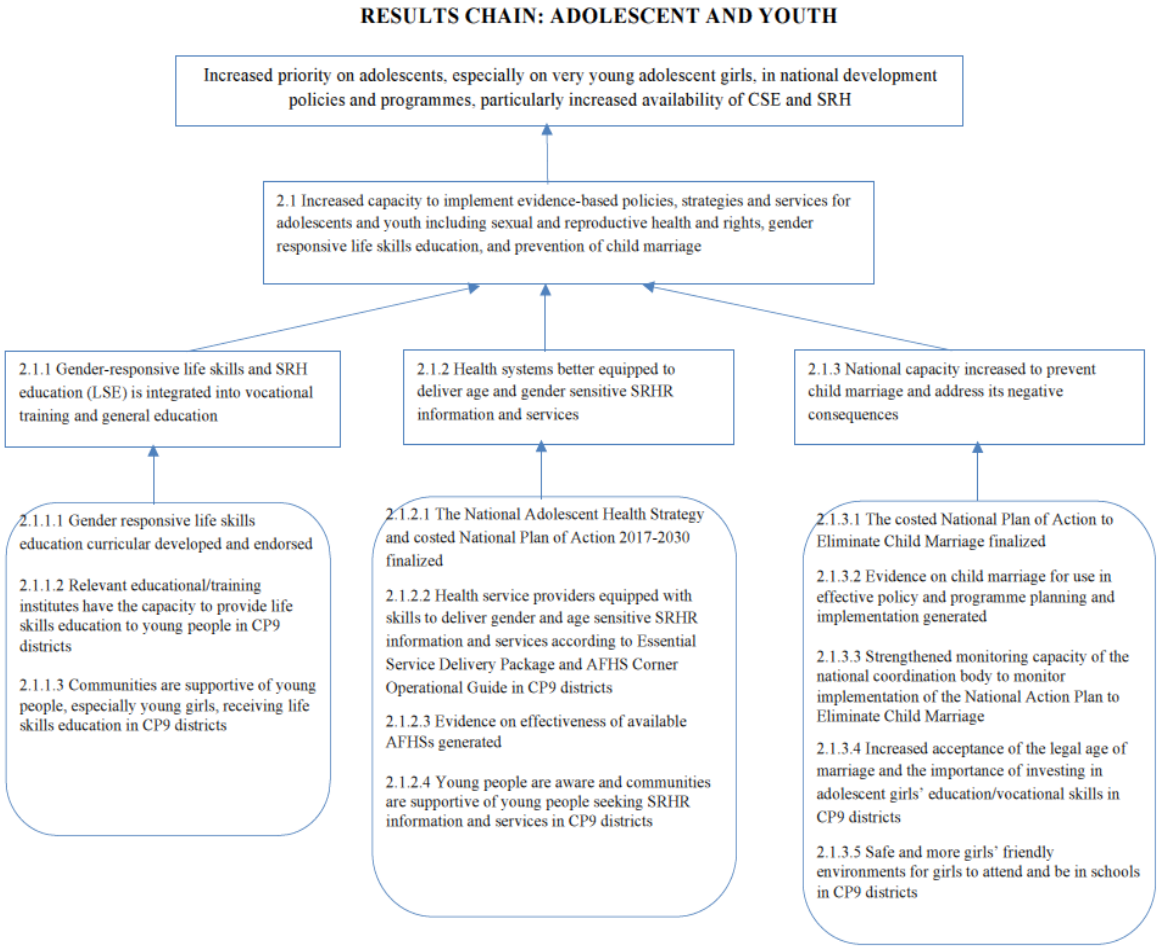
The needs of the population, including the marginalized and vulnerable communities (based on criteria for selection of these target groups), were incorporated taking into consideration their priorities in the design and implementation of the UNFPA CP9 programme and reflecting these in the M&E of programme results. However, M&E system could be more geared towards the assessment of results for vulnerable groups, including disaggregation of data by sex, age and province/district. This seems to be a weak area needing some attention to achieve "no one left behind" objectives by 2030. P&D unit had contributed to the preparation of maps and generation of data to be used in the humanitarian contexts. The P&D component of the country programme and its output and outcome level targets are consistent with national strategies and plans, ICPD and 2030 Agenda.

Annex F: Programme Intervention Logic

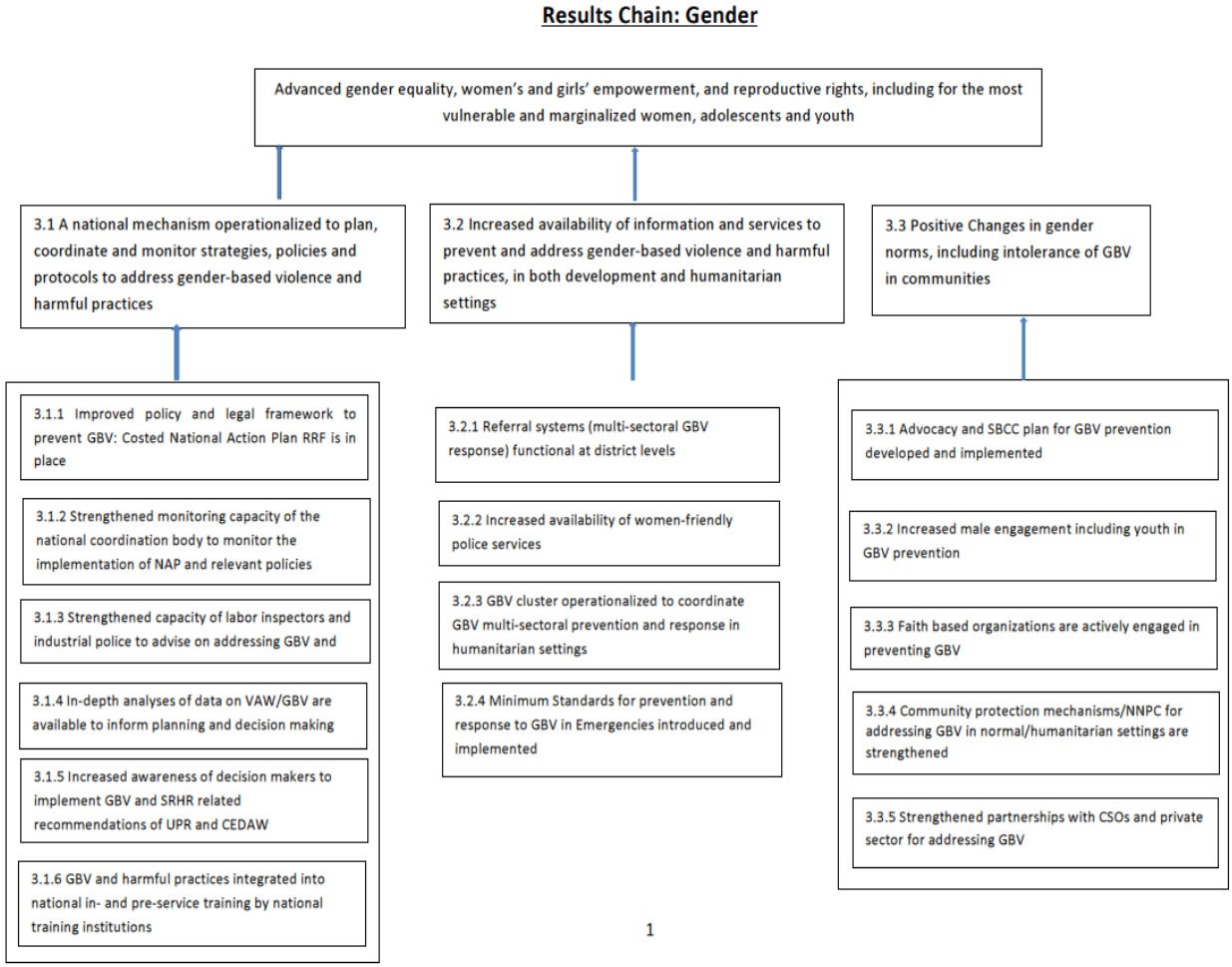
Annex E-Figure 1: Programme Logic - SRHR



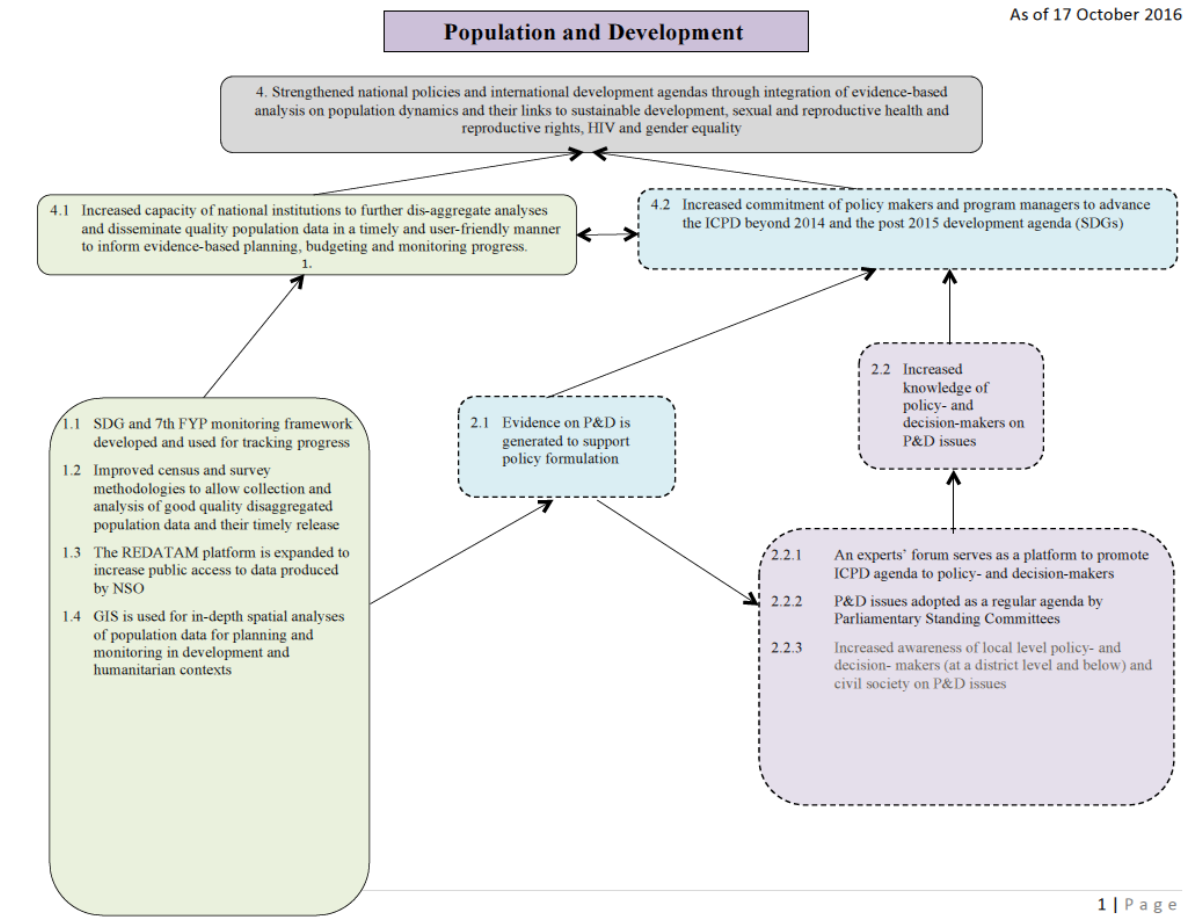
Annex F-Figure 2: Programme Logic Adolescent and Youth



Annex F-Figure 3: Programme Logic: Gender Equality and GBV



Annex F-Figure 4: Programme Logic: Population and Development



(recent updates to this figure are available, but not included in this one)

Annex G: UNFPA Coordination Role

CPE Report Annex F: UNFPA Coordination role in during CP9

UNFPA Position in UNDAF Coordination Structure	
As a Chair/Co-Chair	• UNDAF Programme Management Team Co-Chair (UNDP is a Co-Chair) • UNDAF Outcome 3 Co-Chair (ILO is Co-Convener) • Gender Equality Theme Group Co-Chair (UN Women is a Co-Chair) • Adolescents and Youth Theme Group Chair in 2017 • UNDAF Data Group Co-Chair (UNICEF is a Chair) • UNDAF M and E group Chair (just selected as a chair, was a member before) • Youth Conflict Resolution and Peace Building Working Group Chair
As a Member	• United Nations Country Team • Humanitarian Country Task Team • Security Management Team • UNDAF Outcome 1 and 2 Groups • Theme Group on Adolescents and Youth • Communications Working Group • Human Rights Working Group • Sexual Harassment Legislation Working Group • Senior Emergency Coordination Group • Theme Group on HIV AIDS • Operations Management Team • Local Salary Survey Committee • Procurement Subgroup • Finance Subgroup • Admin Subgroup • Harmonized Approach to Cash Transfers Task Force • Conflict Prevention and Peacebuilding Group
UNFPA Position in ISCG Coordination Structure in Cox's Bazar	
As a Chair/Co-Chair	• GBV Sub-sector Chair • SRHR Working Group Chair • ASRHR Emergency Task Force Co-Chair (IRC is a chair) • GBV Information Management System Chair (UNHCR is a co-chair)

As a Member	• ISCG - Heads of Sub-Offices Group • Sector lead meeting chaired by ISC and RRRC • ASMT- Area security management Team - CXB • Protection Sector • Health Sector • Health sector SAG - Health sector Strategic advisory Group • Education Sector • Logistics Sector • Communications Working Group • Emergency preparedness working group - EPWG • Prevention of Sexual Exploitation and Abuse Network • Gender and Humanitarian Action Working Group • GBV Referral Working Group • Gender Hub (new) under ISCG, acts as gender TA team • Case Management Task Force • Men and boys engagement Task Force • Dignity Kits Task Force • Protection Working Group • Livelihood Working Group • Mental Health and Psychosocial Support Working Group • Communication with Communities WG • Basic Needs Working Group • Community health working group • Emergency Preparedness and Response TaskForce • Operations Task Group •
UNFPA Position in Government Coordination Structures	
As a Chair/Co-Chair	• National GBV Sub-Cluster Co-chair (Ministry of Women and Children Affairs is a chair) • Jamalpur district GBV Sub-cluster Co-chair (Ministry of Women and Children Affairs is a chair) • National SRHR Working Group Chair (for humanitarian coordination) • Youth Working Group Co-Chair (Plan International is a co-chair) • Family Planning Sub-task Group Co-Chair (Ministry of Health and Family Welfare is a chair)
As a Member	• Humanitarian Coordination Task Team • Local Disaster Group - Disaster Emergency Response • Health Cluster (for humanitarian coordination) • Protection Cluster (for humanitarian coordination) • Local Consortium Group for Women's Advancement and Gender Equality • Citizen Initiative for CEDAW • Human Rights Forum for UPR (provide technical assistance to CSO members, not a member) • Skills Working Group • National Adolescent Health Steering Committee • Adolescent Health Network • National Youth Forum

	• Family Planning Technical Forum • Adolescents Family Planning Working Group • Technical Forum for FP 2020 • Health Development Partner Consortium • EMONC Technical Working Group • Demand-side financing Working Group (in health) • Maternal Newborn Health Task Group • Technical Assistance Support Group (in health) • Health financing and Equity Task Group (in health) • Maternal Newborn Adolescent Reproductive Health Task Group • Governance and Stewardship Task Group (in health), under this Gender Equity Voice and Accountability sub-Task Group (in health) • Urban Health Task Group • Sector management Task Group (in health) • Monitoring and Evaluation Task Group (in health) • National Technical Advisory Group (in health) • National Emergency Obstetric Committee • National Health Reform Committee • National Midwifery Committee

Source: UNFPA Bangladesh Country Office

ANNEX H- 1: List of stakeholders by areas of intervention (Atlas IP Code)

(Stakeholder Map is attached (G-2) below)

#	Atlas IP Code	Implementing Partners	Programme Area
1	PGBD03	Bangladesh Police, Ministry of Home Affairs	Gender
2	PGBD04	Department of Women Affairs, Ministry of Women and Children Affairs	Gender and A&Y
3	PGBD05	Directorate General of Health Services, Ministry of Health and Family Welfare	SRHR
4	PGBD06	Directorate General of Family Planning, Ministry of Health and Family Welfare	SRHR
5	PGBD07	Parliament Secretariat	Population & Development
6	PGBD13	Bangladesh Bureau of Statistics	Population & Development
7	PGBD18	General Economics Division, Planning Commission	Population & Development
8	PGBD19	Department of Population Sciences, Dhaka University	Population & Development
9	PGBD21	Directorate of Nursing Service, Ministry of Health and Family Welfare	SRHR

10	PGBD23	National Skills Development Council	A&Y
11	PGBD24	Department of Youth Development, Ministry of Youth and Sports	A&Y
12	PGBD25	National Curriculum and Textbook Board	A&Y
13	PGBD26	Department of Inspection for Factories and Establishment	Gender
14	PN0178	International Centre for Diarrheal Disease Research Bangladesh, NGO	SRHR
15	PN4394	Concerned Women for Family Development, NGO	A&Y
16	PN5774	Research, Training and Management Institute, NGO	SRHR
17	PN6059	Plan International Bangladesh, NGO	A&Y
18	PN6482	Centre for Injury Prevention & Research Bangladesh, NGO	SRHR
19	PN6488	Dalarna University	SRHR
20	PN6619	BBC Media Action Bangladesh, NGO	A&Y and SRHR
21	PN6664	The Population Council, NGO	A&Y
22	PN6690	The Royal College of Midwives	SRHR
23	PN6700	Save the Children International, NGO	SRHR
24	PN6721	Mukti Cox's Bazar, NGO	Gender
25	PN6747	Action Aid Bangladesh, NGO	Gender
26	PN6766	Auckland University	SRHR
27	PN6788	Ipas Bangladesh, NGO	SRHR
28	PN6789	Green Hill, NGO	SRHR
29	PN6790	Hope Foundation Bangladesh, NGO	SRHR
30	PN6817	Gana Unnayan Kendra, NGO	Gender
31	PN6825	Underprivileged Children's Education Programme Bangladesh, NGO	A&Y
32	PN6862	Light House, NGO	SRHR
33	PN6887	Ain o Salish Kendra, NGO	Gender
34	PN6911	Partners in Health & Development, NGO	SRHR
35	PN6913	International Rescue Committee, NGO	SRHR and A&Y
36	PN6991	World Mission Prayer League-LAMB, NGO	SRHR

Annex H-2: Stakeholder Map

Annex G – 2: Stakeholders and key informants list for CPE (national level)

S. No	Stakeholder/organization	Category (UNFPA IP/Collaborating Partner	Name of a key informant	Designation	Contact details of key informants	Role of the key informants in programme
1	Directorate General of Nursing and Midwifery	UNFPA IP	Ms. Tandra Sikder	Director General	**(included email and mobile # and location address)** **(Information on this entire column is deleted on purpose)**	Project Director, UNFPA,s sup HPNSP through DGNM
2	Directorate General of Nursing and Midwifery	UNFPA IP	Zahera Khatun	Director General		Programme Manager, UNFPA, 4th HPNSP through DGNM
3	Directorate General of Health Services (DGHS), MOHFW	UNFPA IP	Prof. Dr. Abul Kalam Azad	Director General		Project Director, UNFPA's Sup HPNSP through DGHS
4	Directorate General of Health Services (DGHS), MOHFW	UNFPA IP	Prof. Dr. Nasima Sultana	Additional Director General - dministration		Project Manager, UNFPA's Su HPNSP through DGHS
5	Economic Relations Division	Collaborating Partner	Monowar Ahmed	Secretary		
6	Economic Relations Division (ERD)	Collaborating Partner	Ms. Sultana Afroz	Additional Secretary, UN Wing Chief		Additional Secretary (UN Wing UNFPA CPAP on behalf of Gov responsible for overall coodin programme
7	Economic Relations Division (ERD)	Collaborating Partner	Baby Rani Kamakar	Deputy Secretary, and Desk Officer (UN)		ERD Desk Officer for UNFPA p
8	Department of Population Sciences, University of Dhaka	UNFPA IP	Prof. Dr. Mohammad Mainul Islam	Chairman & Project Director		Project Director
9	Department of Population Sciences, University of Dhaka	UNFPA IP	Prof. Dr. Aminul Haque	Professor		Former project director
10	Department of Population Sciences, University of Dhaka	UNFPA IP	Mr. Mohammad Bellal Hossain	Associate Prof.		Former project director
11	Population Council	Collaborating Partner	Dr. Ubaidur Rob	Country Director		Work on Population and previ UNFPA IP
12	Department of Youth Development (DYD)	UNFPA IP	Md. Jahangir Alam	Director Implementation, Joint		Project Director

				Secretary		
13	Directorate of Secondary and Higher Education (DSHE)	UNFPA IP	Dr. Mohammed Jahangir Hossain	Director (Planning & Development)		Project Director
14	Bangladesh Bureau of Statistics (BBS)	UNFPA IP	Dr. Krishna Gayen	Director General		Chaiperson of Project Technic (PTC)
15	Bangladesh Bureau of Statistics (BBS)	UNFPA IP	Zahidul Hoque Sardar	Deputy Secretary		Project Director, Stat4Dev. Pr
16	Bangladesh Bureau of Statistics (BBS)	UNFPA IP	Bikash Kishore Das	Additional Secretary		PSC & PTC Member
17	Bangladesh Bureau of Statistics (BBS)	UNFPA IP	Md. Maksud Hossain	Deputy Director		Program Implemention Office
18	General Economics Division (GED)	UNFPA IP	Prof. Shamsul Alam	Member (Senior Secretary)		Chairperson of Project Streein (PSC)
19	General Economics Division (GED)	UNFPA IP	Khondker Ahsan Hossain	Joint Chief		Project Director
20	General Economics Division (GED)	UNFPA IP	Anamika Nazrul	Assistant Chief		Program Implemention Office
21	General Economics Division (GED)	UNFPA IP	Zannatul Ferdous	Deputy Chief, Poverty Analysis and Monitorin (PAM) Wing		Responsible for the coordinat monitoring at GED (person is job)
22	Concerned Women for Family Development	UNFPA IP	Mufaweza Khan	Executive Director		
23	Concerned Women for Family Development	UNFPA IP	Md. Sanwarul Hoque Khan	Project Manager		Project Manager, Generation Project: Phase-II
24	Plan International Bangladesh	UNFPA IP	Orla Murphy	Country Director		
25	Department of Women Affaires, Accelerating Action to End Child Marriage in Bangladesh	UNFPA IP	Jannatul Ferdous	Senior Research Officer		Project Director
26	National Skills Development Council	UNFPA IP	Md. Quamruzzaman	Deputy Director		Project Director
27	Health Economics Unit, MOHFW	UNFPA IP	Dr. Mohd. Shahadt Hossain Mahmud	Director General		Implementation Unit head
28	National Curriculum and Textbook Board	UNFPA IP	Professor Md. Moshiuzzaman	Member, National		Project Director

				Curriculum and Textbook Board		
29	AIDS STD Programme, DGHS	UNFPA IP	Prof. Dr. Md. Samiul Islam	Line Director, TB-L & ASP		Implementation Unit head
30	Light House	UNFPA IP	Harun-or-Rashid	Chief executive		Executive Director
31	Directorate General of Family Planning	UNFPA IP	Dr. Kazi Mustafa Sarwar	Director General		Project Director
32	Directorate General of Family Planning	UNFPA IP	Dr. Mohammed Sharif	Director, MCH Service and Line Director, MCRAH		Managing the MCRAH prograr
33	Directorate General of Family Planning	UNFPA IP	Dr. Md. Moinuddin Ahmmed	Line Director-CCSDP		Managing FP program
34	Directorate General of Family Planning	UNFPA IP	Dr. Md. Sarwar Bari	Director (Finance) and Line Director (FP-FSD)		Managing FP field services
35	Research, Training and Management International	UNFPA IP	Dr. Ahmed-Al Kabir	Chief Advisor		Project Director
36	HOPE Foundation for Women and Children of Bangladesh	UNFPA IP	K.M. Zahiduzzaman	Country Director		Project Director
37	IPAS Bangladesh	UNFPA IP	Dr. Sayed Rubayet	Counttry Director		Project Director
38	Partners in Health and Development (PHD)	UNFPA IP	Abdus Salam	MANAGING DIRECTOR		Project Director
39	International Rescue Committee (IRC), Bangladesh	UNFPA IP	Manish Kumar Agrawal,	Country Director		Project Director
40	Bangladesh Parliament Secretariat	UNFPA IP	Dr. Shirin Sharmin Chaudhury MP	Hon'ble Speaker		Chair, BAPPD
41	Bangladesh Parliament Secretariat	UNFPA IP	M A Kamal Billah	PS to Hon'ble Speaker		Project Director, SPCPD
42	Bangladesh Parliament Secretariat	UNFPA IP	A.K.M Abdur Rahim Bhuyain	Assistant Secretary, Finance		Deputy Project Director, SPCP
43	Centre for Injury Prevention and Research, Bangladesh (CIPRB)	UNFPA IP	Prof Dr MA Halim	Director, Reproductive Health		Project Director

44	LAMB Hospital	UNFPA IP	Swapon Prahan	Director		LAMB Director
45	LAMB Hospital	UNFPA IP	Bapon Mankin	Director		Director
46	Bangladesh Police	UNFPA IP	Md. Saifullah	Additional SP- Special Crime		Project Focal of STOP-GBV
47	Department of Women Affaires, Advancement of Women's Rights	UNFPA IP	Badrun Nessa	Director General (Additional Secretary),		
48	Department of Women Affaires, Advancement of Women's Rights	UNFPA IP	Parveen Sultana	Deputy Director - Training		Project Director of Advancem Women's Rights
49	Department of Inspection for Factories and Establishment	UNFPA IP	Md. Matiur Rahaman,	Deputy Inspector General (DIG),		Project Director of Gender Eq Women's Empowerment at W
50	UNICEF	Partner UN agency	Maya Vandenent	Chief of Health		Leads the UNICEF counterpart
51	UN Women	Partner UN agency	Giulia Pelosi	EVAW programme Specialist		UNW addresses GBV issues, th coordination is needed. Alterr Shohel Rana, Programme Ana email is shohel.rana@unwom
52	WHO	Partner UN agency	Ai Tanimuzua	Nursing and Midwifery		
53	ILO	Partner UN agency	Shammin Sultana	Programme Officer, Gender Mainstreami ng		UNFPA collaborates with ILO o SRHR and GBV in the garment
54	RCO	UN Resident Coordinator's Office	Mia Seppo	Resident Coordinator		
55	RCO	UN Resident Coordinator's Office	Rumana Khan	Head of RCO a.i.		
56	ISCG Protection Cluster (CXB)	UNFPA is leading GBV sub-sector under Protection Cluster	Anna Pelosi	Senio Protection Officer, UNHCR		GBV sub-sector functions und Cluster.
57	ISCG Health Cluster (CXB)	UNFPA is leading SRHR WG under Health Cluster	Dr. Balwinder Singh	Health Sector coordinator		SRHR WG functions under the Cluster
58	Canada	Donor (CP9 SRHR programme and Rohingya refugee	Gabrielle Mathieu	First Secretary Development , Health focal point		Funds the midwifery program

		response)				
59	UK	Donor (CP9 SRHR programme and Rohingya refugee response)	Shehlina Ahmed	Health Adviser, DFID Bangladesh		Funds the midwifery educatio
60	Netherlands	Donor (CP9 A&Y and Gender programmes and Rohingya refugee response)	Ms Mushfiqua Satiar	SRHR and GBV Prevention Advisor		Has been UNFPA's main focal both the Generation Breakthr ASTHA projects.
61	Sweden	Donor (CP9 SRHR programme and Rohingya refugee response)	Carin Zetterlund	Our health focal point		Funds the midwifery program
62	World Bank	Donor (response in CXB for host communities)	Bushra Binte Alam			WB is funding a new project f CXB host communities and Bu focal point. (The project started later in 2