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Sida Decentralised Evaluation

Tana Copenhagen

# Final Strengthening of Safe MR and Family Planning Services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe Menstrual Regulation (MR) programme)

Final Report

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**Final Report  
June 2024**

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The views and interpretations expressed in this report are the authors' and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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# Abbreviations and Acronyms

BAPSA	Bangladesh Association for Prevention of Septic Abortion
CSOs	Civil Society Organizations
DGFP	Director General Family Planning
EC	Executive Committee
ET	Evaluation Team
FGD	Focus Group Discussion
FP	Family Planning
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
Gyn/Ob	Obstetric Gynaecologists
KII	Key Informant Interview
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
MR	Menstrual regulation
MRM	Menstrual regulation medication
NGO	Non-Governmental Organisations
PAC	Post Abortion Care
PAB	Project Advisory Board
PMC	Project Management Cell
RHSTEP	Reproductive Health Services, Training and Education
RTI/STI	Reproductive Tract Infection/Sexually Transmitted Infection
SACMO	Sub-Assistant Community Medical Officer
Sida	The Swedish International Development Cooperation Agency
SMH	Safe Motherhood
SRHR	Sexual and Reproductive Health and Rights
WBS	Work Breakdown Structure
WRA	Women of Reproductive Age

# Preface

This evaluation was contracted by FCG through the Swedish International Development Cooperation Agency (Sida) Framework Agreement for Evaluation Services and conducted by Tana Copenhagen. The Evaluation Team consisted of Tom Mogeni Mabururu (Team Leader) and Tasnia Ahmed (Team Member). Grace Muchunu (Tana Copenhagen) provided project management support.

This Draft Report was prepared by the evaluation team consisting of Team Leader Tom Mogeni Mabururu and Team Member Tasnia Ahmed. Independent quality assurance was provided by Susan Tamondong whose work was independent of the evaluation team.

The team would like to thank Zahirul Islam from Sida, Quazi Suraiya Sultana (Executive Director, RHSTEP) Altaf Hossain (Executive Director, BAPSA), Md. Mahbubul Haque and Dr Elvina Mustary (RHSTEP) and Md. Kaswer Karim (BAPSA) for their cooperation and coordination of the evaluation. In addition, the team is grateful for the interactions with RHSTEP and BAPSA staff at the head office and in the centres, MoHFW and beneficiaries who provided invaluable input to this evaluation.

# Executive Summary

This report presents the findings, conclusions, and recommendations of the valuation of the Strengthening of Safe MR and Family Planning services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe Menstrual Regulation (MR) programme). This is a programme funded by Sida and implemented by RHSTEP and BAPSA. This evaluation covered the 2017-2022 phase of the programme.

The evaluation was undertaken in line with the UNEG norms and standards and Sida evaluation guidelines. It applied the OECD/DAC criteria. Data was collected through key informant interviews (KIIs), focus group discussions (FGDs) and documents review. The evaluation faced limitations – the timeframe for data collection was not adequate to conduct all KIIs and FGDs; and there were challenges in engaging community groups and beneficiaries during working hours. The evaluation team adopted a virtual and physical approach for data collection in order to better manage time; and conducted some FGDs outside working hours in order reach all beneficiaries. The programme did not have a theory of change at the design stage, and instead utilised a logical framework. A theory of change (ToC) was constructed at inception and applied.

## Findings

### Relevance

The Safe MR Programme was aligned with Sida's SRHR priorities and contributed to the realisation of the outcomes of the Swedish SRHR strategy for Bangladesh. Furthermore, the programme ToC was well linked to the Swedish SRHR strategy ToC. The programme also responded to the health and SRHR needs of women and adolescents which were identified from surveys, national strategic frameworks and through engagement with stakeholders. These included need for menstrual regulation, post abortion care, family planning and safe motherhood and breast and cervical cancer screening. However, the programme response to the needs of women with disabilities and LGBTQI people was limited.

### Effectiveness

The consortium (RHSTEP and BAPSA) trained government, NGO and private service providers which contributed to expansion of the availability of MR/MRM, PAC and FP among other SRH services. The consortium also trained their own staff in SRH and management areas to improve both the quality of clinical services and improve programme implementation. To a large extent, targeted populations accessed the SRH services (including MR, PAC, FP and Safe Motherhood among others) offered in the



RHSTEP and BAPSA clinics. This notwithstanding, socio-cultural norms and practices, religious beliefs, family level barriers, stigma and fear especially among adolescent girls, and low awareness on MR regulations and overall SRH knowledge hindered women and girls from accessing SRH services. Community interventions tailored at addressing some of these barriers were implement at too limited a scale to have an effect. In addition, advocacy interventions were implemented as planned especially in the first two years, but the advocacy agenda being pursued was not well defined.

#### Efficiency

RHSTEP and BAPSA had the capability to implement the Safe MR Programme. Its management bodies – Executive Committees and Project Advisory Committee - functioned as expected. Financial and procurement and supply management systems, management information system, and internal and external audits contributed to improved programme management, implementation and accountability. However, there is room for improvement of the internal controls. The consortium had skilled and experienced staff at the head office but the staff are not adequate. Similarly, the clinics have trained staff but they are also not adequate. The clinics have a shortfall of about 30% of the core staff.

#### Sustainability

Although there is no financial sustainability plan in place, the two organisations have strategic plans guiding their activities towards sustainability. Some of the strategies include charging fees for services offered, with an option of providing free services to the poor; establishment of a training centre, phasing out clinics that have attained financial sustainability<sup>1</sup> from the programme; mobilising resources from other donors with a certain degree of success; a plan to establish a marketing unit<sup>2</sup> and digitising the organisations. The likelihood of these strategies being implemented beyond the programme period is assessed as moderate given that the strategies will require funding beyond the income the consortium is generating.

#### Cross-cutting issues

The Consortium has developed policies and guidelines for mainstreaming gender equality and a human rights-based approach into the programme. Staff has been trained on these policies and guidelines but they have not been fully operationalised because it takes time to change attitudes and mindsets of staff to be gender sensitive and develop expertise in gender mainstreaming. In addition, platforms for women to have their voice heard were not established.

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<sup>1</sup> The phase out of clinics means these clinics no longer receive funding support from the programme because are able to generate adequate income to support service delivery.

<sup>2</sup> The role of the marketing unit will be to mobilise resources and increase visibility of the Consortium services and the results being achieved.

## Conclusions

### Relevance

Safe MR Programmes was well aligned with the Swedish SRHR Strategy for Bangladesh and its ToC. The programme was also relevant to and addressed the health and SRHR needs of women and girls. However, the programme did not clearly define SRH needs of women with disabilities and LGBTQI people.

### Effectiveness

- Training on MR, PAC, FP (among other SRHR areas) is a key comparative advantage of RHSTEP and BAPSA which is well recognised by the government and other NGOs. As a result, the MoHFW/DGFP has retained both organisations as a key training service provider in its annual training plans. However, there is a need for improving the collaboration with MoHFW to ensure timely invitations and to address any concerns service providers may have on the trainings to ensure all participants attend training.
- A significant proportion of the targeted groups accessed SRH services in the RHSTEP and BAPSA clinics. However, WRA including adolescent girls continue to face socio-cultural, religious, and stigma barriers compounded with low awareness of SRHR. Furthermore, there was no specific approach for reaching out to women with disabilities and LGBTQI people.
- Services provided by RHSTEP and BAPSA clinics vary according to location, patient flow and capacity of the clinics. Services are also offered depending on the type of staff in place as shown in the clinic staffing analysis.
- Knowledge and awareness on SRHR is still a huge need in the community, among adolescents and youth and for garment factory workers. However, community interventions were implemented at small scale and less intensity due to limited funding

### Efficiency

- RHSTEP and BAPSA have the governance, financial, procurement and supply chain, programme management and training as well as internal audit capability to implement the safe MR programme, but weaknesses were identified in internal controls. The organisations also have the skilled staff needed to manage and implement programmes but the number of staff is inadequate.
- Although RHSTEP has established some capability for undertaking research, this capability is not adequate and the research so far undertaken has not been utilised adequately. BAPSA, on the other hand, is yet to establish research capability.

### Sustainability

Sustainability remains a major concern. RHSTEP and BAPSA have not developed a financial sustainability plan and the sustainability strategies being pursued will require additional funding, take time to implement and realise results.

### Gender and human rights integration

Integration of gender equality and human-rights based approaches in the MR programme is at the initial stages, having developed policies and guidelines for mainstreaming. However, it will take time to change mindsets and build adequate capacity for gender and human-rights based approaches mainstreaming.

### Recommendations

- In the next Safe MR Programme, RHSTEP and BAPSA should consider including: 1) component on pharmacies linkage or partnership; 2) a scale up of mobile services; 3) establishing community to clinic referral; 4) prioritising clinics based in rural areas to enable the programme strengthen linkages to a revamped community component.
- In the next Safe MR Programme, the community component should be scaled up through innovative approaches.
- RHSTEP and BAPSA should develop an action plan with clear goals, indicators and timelines for integration of gender equality and human rights (including establishing platforms for women's voice, integrating women with disabilities and LGBTQI people) in the next Safe MR Programme.
- In the next Safe MR Programme design: a) SRHR (particularly MR, PAC, FP) advocacy needs should be well defined, have a clear ToC and appropriate implementation modalities. b) Ensure coherence of the programme through strengthening linkages between community sensitisation, demand creation for MR and other SRH services, advocacy, and community clinics linkage.
- In the next Safe MR Programme, RHSTEP and BAPSA should consider recruiting: 1) an M&E expert; and 2) a community outreach and advocacy expert to strengthen these aspects of the programme
- RHSTEP and BAPSA should consider developing a costed research agenda based on a well-defined research priority. The strategy should include documentation of best practices and lessons; and the utility of research recommendations.
- RHSTEP and BAPSA should consider developing a long-term clinic specific growth plan which will include expected income growth
- The consortium should consider undertaking an organisational development for BAPSA with emphasis on strengthening financial and procurement and supply management and internal controls.
- To enhance sustainability, consider: (a) developing a financial sustainability plan with targets, work plan and cost; (b) scale up digitisation of the two organisations to improve efficiency
- RHSTEP and BAPSA should develop an investment case for establishing a training centre for SRHR.

# 1 Introduction

## 1.1 BACKGROUND, PURPOSE AND OBJECTIVES

### **Background**

The Strengthening of Safe MR and Family Planning Services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe Menstrual Regulation (MR) programme) is designed to contribute to the improvement of Sexual and Reproductive Health and Rights (SRHR) and well-being of women and adolescents. The Embassy of Sweden in Bangladesh has been supporting two national Non-Governmental Organisations (NGOs) - Reproductive Health Services, Training and Education (RHSTEP) and Bangladesh Association for Prevention of Septic Abortion (BAPSA) to implement the MR programme since 2004. The two organisations are pioneers and have established a niche in providing quality and safe MR services, management of abortion complications and prevention of unsafe abortion in the country. Both organisations collaborated in the implementation of this programme in order to leverage each other's capacities and increase the programme's geographical and target population coverage. This evaluation assessed the current phase of the safe MR programme covering the period October 2017 to December 2022.

This evaluation was carried out at a time when Sida's support to RHSTEP and BAPSA is ending and Sida is planning to assess the continuation of the support to the safe MR programme. This evaluation is expected to enable Sida to understand the added value, comparative advantage, effectiveness and how RHSTEP and BAPSA can influence sexual and reproductive health (SRH) services beyond this programme.

The evaluation is a key input in the appraisal of the planned support to RHSTEP and BAPSA; the dialogue with both organisations on the programme itself and SRHR issues in Bangladesh; and the evaluation conclusions and recommendations will be useful for future cooperation. This evaluation also provides the Embassy of Sweden in Bangladesh lessons on the relevance of the programme to its SRHR strategic objective and theory of change (ToC).

### **The purpose of the evaluation**

The purpose of this evaluation was to assess the safe MR programme and its contribution to Sweden's Development Cooperation objective related to SRHR: "Better opportunities for access to, and respect for, sexual and reproductive health and rights".

### Objectives of the evaluation

The objectives of the evaluation were as follows:<sup>3</sup>

1. Assess the programme strategies, implementation and accomplishments as well as challenges and how they have been solved during the implementation period 2017-2022;
2. Measure the achievements of the programme against the set outcomes and related indicators;
3. Assess funds budgeted and spent, the division of funds on different types of expenses and estimated cost-efficiency;
4. Review the long-term sustainability strategy of RHSTEP and BAPSA;
5. Assess the collaboration among government, and RHSTEP and BAPSA and the extent to which the programme is integrated into the health system.

The *intended primary users* of this evaluation are the Swedish Embassy in Bangladesh and RHSTEP and BAPSA. The primary use of the evaluation is to: (i) help Sida to assess progress of the intervention as an input to upcoming discussions of a new phase of the intervention; and (ii) serve as an input for Sida in the overall dialogue and advocacy of SRHR in Bangladesh.

## 1.2 SCOPE OF THE EVALUATION

The evaluation covered all programme activities implemented from October 2017 to December 2022. Regarding the thematic scope, the evaluation assessed programme inputs, activities and results under all programmatic output areas and cross-cutting themes of gender equality and human rights-based approach to programming. Data for the evaluation was collected at national, district, clinics (centres) and community levels where programme activities were implemented.

## 1.3 EVALUATION CRITERIA AND QUESTIONS

The evaluation criteria and questions are outlined in the Terms of Reference (Annex 1). The evaluation criteria included relevance, effectiveness, efficiency and sustainability. It also included cross-cutting themes of gender equality and human rights-based approaches. The evaluation questions for each criterion are presented in the evaluation matrix in Annex 2 and used as subheadings in the findings chapter.

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<sup>3</sup> Terms of Reference page 3.

## 2 Methodology

### 2.1 OVERALL APPROACH

The evaluation applied a theory-based approach to assess the programme pathway to change and probe how its activities led to output results; and how outputs contributed to the programme outcomes; and the extent to which the underlying assumptions influenced the achievement or non-achievement of programme results. The MR programme did not have an explicit theory of change but it did have a logical framework. A theory of change was reconstructed and applied during the evaluation to assess the causal links from inputs and activities to outputs and from outputs to outcomes; the extent to which programmes assumptions held true; and the key actors and the roles they played in the realisation of programme results.<sup>4</sup>

Other approaches used for evaluation include the mixed methods approach for data collection; stakeholder participation in the evaluation especially as sources of information; the design of the evaluation matrix which guided the evaluation at design, data collection, analysis and reporting stages; and gender mainstreaming into the evaluation. The inception report outlined the evaluation approach and methodology which is summarised in Annex 3.

### 2.2 METHODS AND TOOLS FOR DATA COLLECTION

The evaluation team collected data using the following methods:

#### Desk review of documents

An extensive review of documents relevant to each evaluation question was conducted. Documents reviewed included Sida's strategy for Bangladesh; national policies, strategic plans and guidelines related to SRHR, MR and abortion; programme documents such as the programme proposal, results framework, work plans, annual reports, previous evaluation reports, programme data, financial data, audit reports, programme management reports and knowledge products; and published papers and grey literature. The documents reviewed are listed in Annex 5.

#### Key informant interviews

Key informants were selected from a comprehensive mapping of programme stakeholders. Key informants were purposively selected to ensure all evaluation questions can be answered and also to ensure key informants can provide information on all the programmatic and cross-cutting themes. Semi-structured interview guides

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<sup>4</sup> Reconstructed ToC is presented in section 4 under relevance.

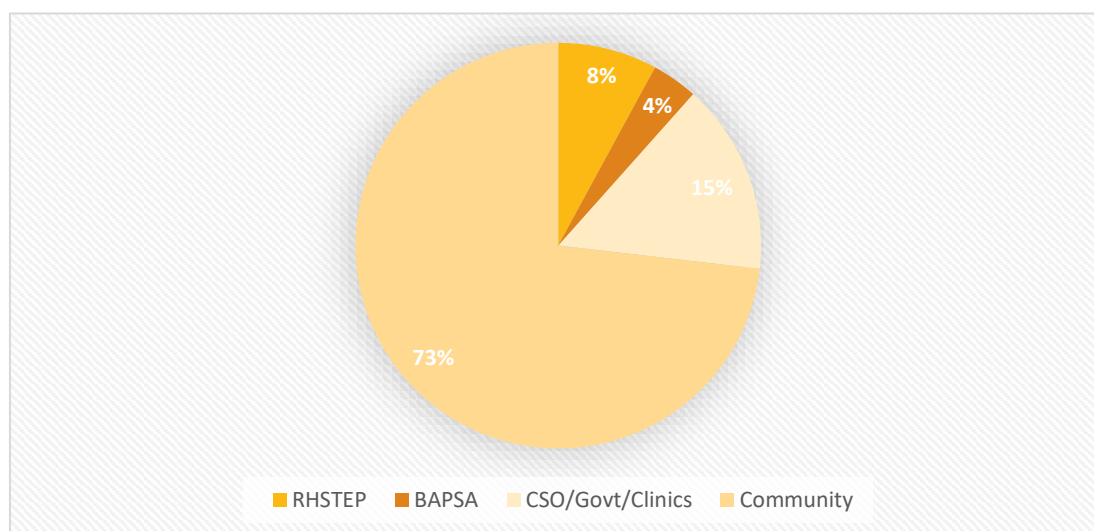
tailored to each type of key informant were developed and applied during the interviews.

#### Focus group discussions (FGDs)

Programme beneficiaries were interviewed through FGDs. These included women, girls and men who accessed services at RHSTEP and BAPSA clinics; adolescent girls and boys, and young girls and boys who were beneficiaries of the programme SRHR awareness interventions; garment factory workers and school students provided SRH services and education; and women groups, community leaders, and community support groups sensitised on SRHR. FGD guides tailored to each beneficiary group were used during FGDs.

A total of 120 people were interviewed. These are disaggregated as shown in Figure 1 below and the list of people interviewed is provided in Annex 4.

**Figure 1: Proportion of people interviewed by stakeholder category**



The selection of districts and clinics where data was collection was based on four criteria: 1) client flow: 2 sites with high client flow and 2 sites with low client flow were selected; 2) concentration of programme activities to ensure the sites selected are a good representation of programme implementation; 3) convenience to ensure the evaluation team can reach the sites within reasonable time and complete data collection within set time frame; and 4) coverage of RHSTEP and BAPSA programme sites with two sites selected for each organisation. The four sites selected through applying these criteria were Sylhet and Dhaka (Shewrapara) districts covering RHSTEP activities; and Dhaka (Mirpur-6) and Gazipur (Board bazar) districts covering BAPSA activities.

## 2.3 DATA ANALYSIS

Data was analysed using quantitative and qualitative analysis techniques. Simple descriptive quantitative analysis was used to analyse programme output indicator data comparing targets verses results achieved to show the level of programme performance.



Financial data was also analysed using the quantitative analysis techniques to compare programme annual budgets against expenditure by programme outputs in order to establish the expenditure rates. Income from RHSTEP and BAPSA clinics was also compared with projected income per year to assess the extent to which both organisations achieved the expected matching funds. The estimated unit costs were also compared with actual unit costs for categories of activities to establish positive or negative variances in order to assess cost efficiency to a certain degree.

Qualitative data analysis technique was used to analyse qualitative data. Qualitative data was categorised according to the relevant evaluation questions; data from the same source was analysed to establish patterns and emerging themes; this was followed by re-categorising of data from all sources to identify the emerging patterns and themes across data sources, points of convergence and to establish the evaluation findings. Lastly, data from the same sources and data collected using the same methods was triangulated to minimise evaluator bias and establish evidence for the findings.

## 2.4 LIMITATIONS

The evaluation limitations and mitigation measures are explained in the table below:

**Table 1: Limitations and mitigation measures**

Limitation	Mitigation and team response
The period allowed for data collection was not adequate to cover all selected key informants and focus group discussions. The period could not be extended due to financial limitations.	The evaluation team conducted interviews and FGDs separately and key informants located outside Dhaka (other than those in districts selected for field data collection) were interviewed virtually in order to complete data collection within the set period.
Some community groups were not available during working hours because they are working in different professions, such as garment workers, home makers, etc.	Some of the FGD were conducted outside working hours to accommodate these groups

## 2.5 ETHICS AND PARTICIPATION

The evaluation team adhered to the Tana Copenhagen's Research Ethics Guidelines which are benchmarked against the UN Evaluation Guidelines, and norms and standards. The ethical guidelines include sensitivity to gender, cultural and religious beliefs, manners and customs; integrity and honesty and ensuring inclusiveness of views. The team also safeguarded the rights and welfare of participants by ensuring the anonymity and confidentiality of key informants and FGD participants. Interviews were undertaken in a private set-up that ensured confidentiality, key informants and FGD participants were informed of their rights to choose to participate or withdraw from the interview and requested their consent. The evaluation team also adhered to Tana's ethical guidelines which encompass the organisation's approach to human rights, labour conditions, the environment, anti-corruption and bribery.





# 3 The Evaluation Object: The MR Programme

## 3.1 INTRODUCTION

The safe MR programme is designed to contribute to the improvement of SRHR situation and well-being of women and adolescents in Bangladesh. This programme is managed and implemented by RHSTEP and BAPSA consortium and funded by Sida with the consortium expected to provide agreed matching funds. The current phase of this programme started in October 2017 and ended in December 2021. The programme was extended in December 2021 for 15 months which will end in June 2023. However, the programme activity period ended in December 2022.

The purpose of the programme is to reduce maternal mortality and morbidity from unsafe abortion and improve the SRHR situation for women and adolescents in programme areas. Programme objectives include: i) to improve access to MR and PAC services; ii) provide SRHR services to the youth and adolescents; iii) create awareness and generate demands for SRH services and rights; iv) strengthen advocacy and policy dialogue to create an enabling environment for safe MR and SRH services and rights; v) generate and disseminate evidence for improved SRH services and Policy influence; vi) use of ICT for transparency, accountability and better management system; and vii) improve sustainability of the SRHR consortium.

The programme outcomes and outputs are outlined in the Table 2 below.<sup>5</sup>

**Table 2: Outcomes and outputs of the programme**

Outcome	Outputs
<b>Outcome 1:</b> Improved Skills of Service providers for SRHR services	<b>Output 1:</b> Service providers, community volunteers receive training on MR/MRM and other SRHR issues
<b>Outcome 2:</b> Improved capacity of the consortium in SRHR program management	<b>Output 2:</b> Consortium staff improve skills on SRHR service delivery and other program management related issues
<b>Outcome 3:</b> Increased access to quality SRHR services for women, adolescents and men	<b>Output 3:</b> Women, men and adolescents receive MR and SRH Services from the consortium clinics as needed
<b>Outcome 4:</b> Enhanced knowledge of the women and adolescents in the project areas	<b>Output 4:</b> Women, men, and adolescents receive information on SRHR

<sup>5</sup> From the MR programme document.

to make informed choice pertaining to their sexual and reproductive health needs	
<b>Outcome 5:</b> Strengthened monitoring, Research, Evaluation and Documentation processes in the consortium	<b>Output 5:</b> Necessary monitoring visit, organisational meetings, partner meetings and research studies on MR and SRHR related issues are conducted
<b>Outcome 6:</b> Strengthened advocacy and social networking initiatives for improving SRHR situation.	<b>Output 6:</b> Advocacy is strengthened through network meetings, coordination meetings with local and national health and other authorities, issue-based seminars, national and international days observation organised at central and local level with different stakeholders
<b>Outcome 7:</b> Sustainability of the consortium improved	<b>Output 7:</b> Sustainability of the pro poor and quality MR and PAC programme and SRHR consortium after the project period is improved

## 3.2 PROGRAMME BUDGET

The programme budget summary for the period 2017-2022 in BDT is shown below.

**Table 3: Programme budget**

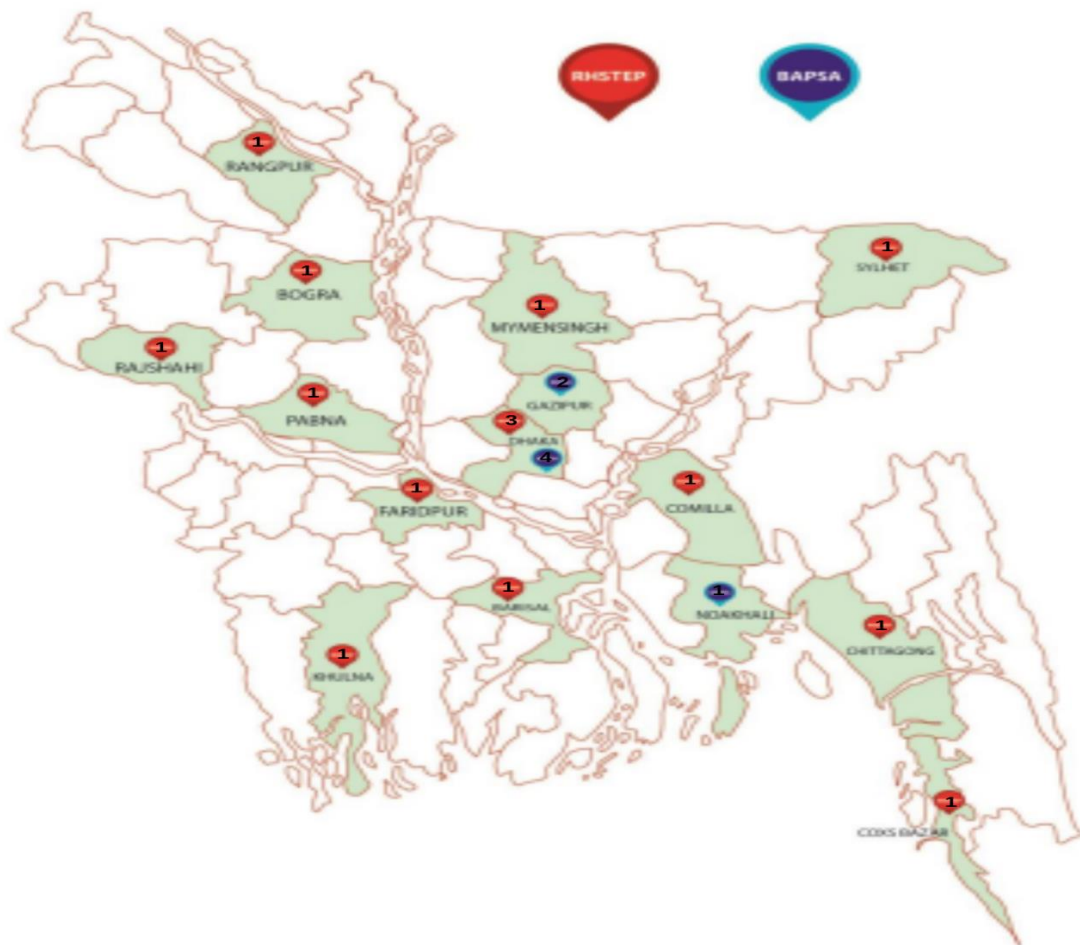
Outputs <sup>6</sup>	2017/2018	2018/2019	2019/2020	2020/2021	Oct-Dec 2021	Jan-Dec 2022	Total
Output-1	27,565,890	26,551,124	26,228,090	25,312,447	4,731,887	22,263,160	132,652,598
Output-2	13,670,475	13,003,367	13,891,434	12,960,822	2,206,410	11,753,843	67,486,351
Output-3	56,756,666	54,138,873	48,794,371	51,116,528	11,744,528	43,711,672	266,262,638
Output-4	21,199,573	20,018,954	21,161,224	21,822,028	3,545,725	16,598,713	104,346,217
Output-5	5,355,643	5,443,396	5,896,654	8,322,795	1,021,815	8,253,835	34,294,138
Output-6	4,460,052	4,391,688	5,004,840	4,980,053	815,852	4,500,010	24,152,495
Output-7	7,139,330	6,548,659	7,257,082	6,945,820	1,407,203	6,513,131	35,811,225
<b>Total</b>	<b>136,147,629</b>	<b>130,096,061</b>	<b>128,233,695</b>	<b>131,460,493</b>	<b>25,473,421</b>	<b>113,594,364</b>	<b>665,005,663</b>

<sup>6</sup> For output headings, see Table 2.

### 3.3 GEOGRAPHICAL AREA AND TARGET POPULATION

Under this programme, RHSTEP was expected to provide SRH-related services in 16 clinics which include those located in government medical colleges and district hospitals and one maternity clinic located outside government premises. BAPSA was to provide SRH-related services in 7 (seven) clinics. The map below shows the geographical spread of clinics supported by the Safe MR programme.

**Figure 2: Geographical spread of the RHSTEP and BAPSA service centres**

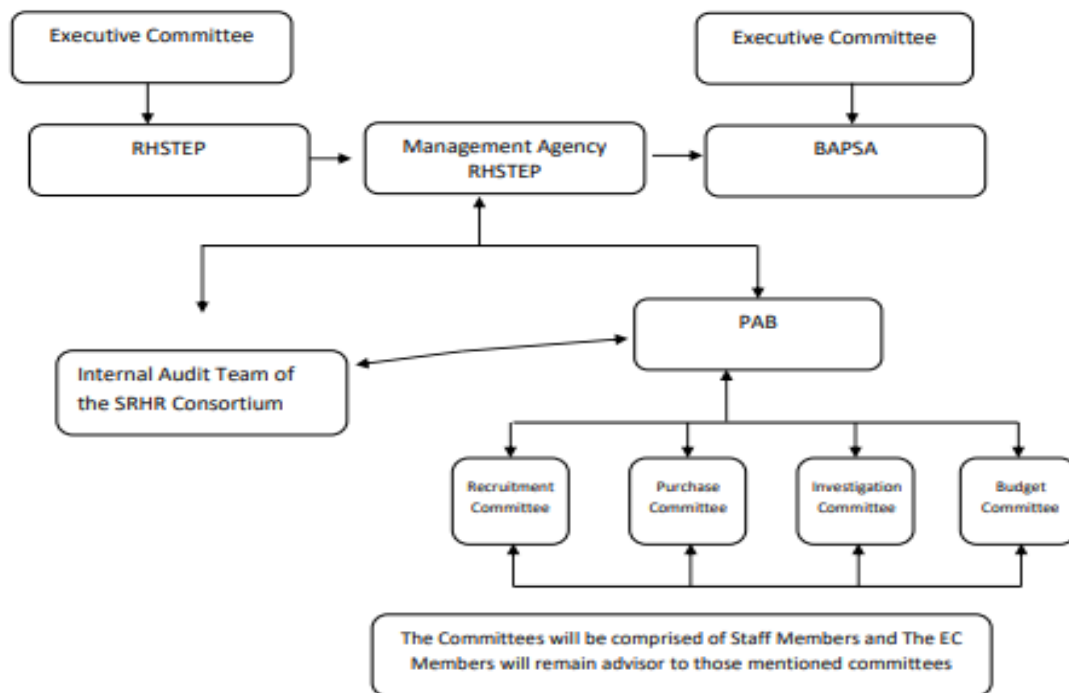


Target populations for this programme are: a) Healthcare workers/ service providers including doctors, nurses, paramedics, Sub-Assistant Community Medical Officers (SACMOs), Family Welfare Visitors (FWVs); b) Women of Reproductive Age (WRA); c) adolescent and youth boys and girls 10-24 years; d) policymakers; and e) community gatekeepers including parents, religious leaders and teachers.

### 3.4 GOVERNANCE AND IMPLEMENTATION ARRANGEMENTS

The consortium (RHSTEP and BAPSA) established two key structures for the management and implementation of the programme: a) the Executive Committee of the Consortium (EC), and the b) Project Advisory Board (PAB). Below is the organogram of the implementation arrangements.

**Figure 3: MR programme governance and implementation arrangements**



#### Executive Committee (EC)

The EC of each organisation is responsible for policy formulation, approval of programme activities and budgets, overseeing financial and programme activities, monitoring of field level programme implementation and review of progress in programme implementation. Decisions of the EC are obligatory for implementation. Most EC members are obstetric gynaecologists, thus are fully aware of the SRHR issues and able to guide programme implementation.

#### Project Advisory Board (PAB)

Formed jointly by the two consortium members, the PAB consists of three senior programme experts of RHSTEP and BAPSA and jointly supervise and monitor programme activities. Other roles include compiling work plans and budgets, obtaining approval from the NGOAB, arranging programme audits, ensuring use of common financial management systems and reviewing programmatic and financial reports.

#### Programme management by individual partner NGO, RHSTEP and BAPSA

Each partner is expected to manage and implement its programme activities with guidance from the partner EC and the Executive Director. Central offices of each organisation supervise and monitor activities, recruit personnel, develop financial and programmatic plans, procure and supply equipment and commodities and report on the programme activities.

#### Monitoring

The programme has a logical framework and associated tools for data collection. The consortium established a centralised results-based monitoring framework to ensure data gathered at different levels informs programme performance review and reporting. Both organisations have in place financial, medical and programmatic monitoring teams which monitor their respective areas and provide feedback to the PAB. The two organisations use common monitoring tools; activities are tracked on a monthly basis; output indicators are monitored and reported on half yearly; and outcome monitoring is carried out annually.

## 4 Findings

This chapter presents the findings for each criterion and evaluation question based on the analysis of the collected data. The chapter is structured according to the five criteria and questions under each criterion.

### 4.1 RELEVANCE

***EQ 1: Is the program relevant to the Swedish strategy for Bangladesh and the Theory of Change (ToC) of the strategy and the health and SRHR needs of the target group?***

**Finding 1.1a: The Safe MR Programme was consistent and well aligned with Sida SRHR priorities.**

The safe MR programme is consistent and aligned with the Swedish SRHR Strategy for Bangladesh which prioritises “better opportunities for access to, and respect for sexual and reproductive health and rights”. The strategy prioritises activities that promote access to SRH services and information such as capacity building and comprehensive sexuality education.<sup>7</sup>

The Safe MR Programme interventions aligned with the SRHR priorities of the Swedish strategy for Bangladesh include: (1) the training of service providers on SRHR (including MR, PAC and FP); (2) the provision of the SRHR services such as MR, PAC, FP, sexually transmitted infections (STI) and reproductive tract infections (RTI) and breast and cervical cancer screening among others; (3) SRHR awareness; and (4) advocacy to create an enabling environment for access to SRHR services.<sup>8</sup>

**Finding 1.1b: The ToC for the Safe MR Programme is linked and contributed to the realisation of the Swedish SRHR strategy ToC. However, SRHR awareness and advocacy interventions did not contribute adequately to the Swedish SRHR strategy TOC because they were downscaled from 2020.**

The Safe MR programme did not have an explicit theory of change but it did have a logical framework which elaborated the activities, outputs and outcomes of the programme.<sup>9</sup> The evaluation team used the logical framework, programme data and feedback from key informants and beneficiaries to construct the programme ToC.

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<sup>7</sup> Strategy for Sweden's development cooperation with Bangladesh 2021-2025.

<sup>8</sup> Proposal for strengthening of safe MR, family planning services and reduction of unsafe abortion for improving SRHR situation in Bangladesh (Safe MR Project), July 2017 - June 2021.

<sup>9</sup> Proposal for strengthening of safe MR, family planning services and reduction of unsafe abortion for improving SRHR situation in Bangladesh (Safe MR Project), July 2017 - June 2021.

The programme ToC illustrates the pathway to change as follows<sup>10</sup>: **IF** (a) healthcare service providers are trained on SRH (MR, PAC, FP, Safe Motherhood (FMH)); (b) RHSTEP and BAPSA clinics are equipped with required medicines, equipment and supplies; (c) Women, girls as well as community gate keepers such as community and religious leaders are sensitised on SRHR and (d) an enabling policy environment is established and sustained; **THEN** women and girls, men and boys will access quality MR, PAC, FP and other SRHR services. This was expected to contribute to the Swedish SRH Strategy short-term outcomes: increased demand and utilisation of SHR (MR and PAC) services, reduced stigma and increased trust in health providers which in the long-term contributes to enhanced capacity to provide high-quality health and medical care and better opportunities for access to and respect for SRHR.<sup>11</sup>

The programme ToC was realised to a large extent: (a) the programme invested significant resources to train doctors, nurses, paramedics, Family Welfare Visitors (FWVs)<sup>12</sup> and SACMOs to expand MR and PAC services in government, private and NGO health facilities. (b) the programme supported the procurement and supply of SRH (MR, PAC, RTI/STI etc) medicines, equipment and supplies for RHSTEP and BAPSA clinics. (c) the programme supported SRHR awareness activities targeting schools, garment factories, youth groups (Alodhara Patshala) and communities but these were downscaled from 2020 due to funding limitations. (d) The programme supported a large number of networking and advocacy events at national and district levels but the issues that were being advocated for were not well defined and limited actions were taken as a follow up to these events.<sup>13</sup>

Most of the programme assumptions held true. Government health service providers trained were provided with required equipment, medicines and supplies to provide MR, PAC and FP services. The MR and guidelines are in place and provide clear guidance to service providers on the provision of MR services. Women and girls were able to overcome cultural barriers to access MR, PAC and MR services although these barriers still remain. An assumption that was not foreseen at programme design was the increase in the number of women and girls accessing MR medicine in pharmacies and drug stores contributed to the reduction in the number of women and girls seeking these services in health facilities. A limited number of men and boys seek SRHR services in RHSTEP and BAPSA clinics as these facilities are perceived to serve mainly women and girls. In addition, there was no evidence of LGBTQI people seeking services in these clinics.<sup>14</sup>

<sup>10</sup> Key informant interviews with RHSTEP, BAPSA staff, NGOs and review of annual programme reports.

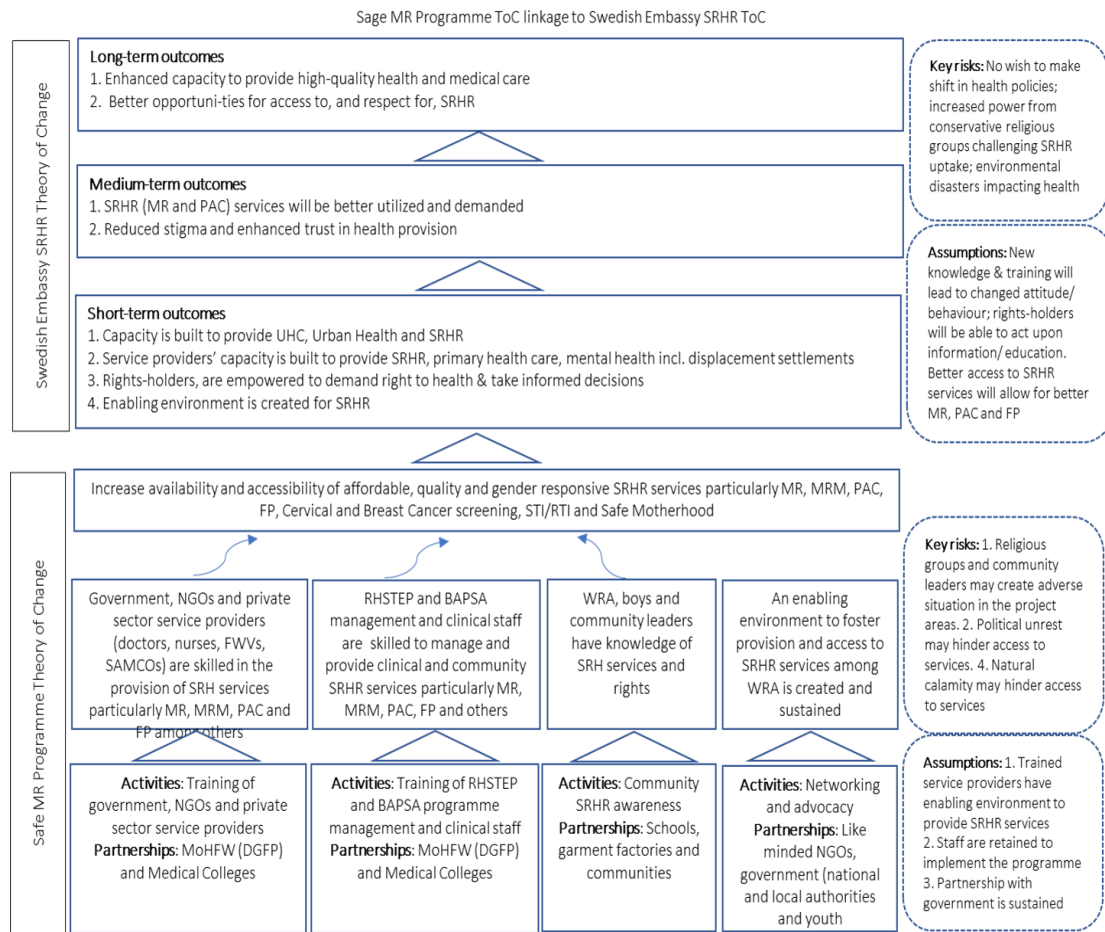
<sup>11</sup> Review of Swedish Strategy for Bangladesh Theory of Change and interviews with Sida Bangladesh.

<sup>12</sup> FWVs are stationed primarily in remote areas at union health and family welfare centres (UHFWCs) throughout Bangladesh, under the Directorate General of Family Planning.

<sup>13</sup> Key informant interviews with RHSTEP, BAPSA staff and government officials, trainers and trainees, review of training reports and programme annual reports and programme data.



**Figure 4: Safe MR Programme ToC linkage to Swedish Embassy SRHR Strategy ToC**



**Findings 1.1c: The Safe MR programme responded to the health and SRHR needs of the women and girls which included needs for menstrual regulation, post abortion care, family planning and safe motherhood and breast and cervical cancer screening.**

The safe MR programme design was informed by findings of various surveys and studies. This included the Demographic and Health Survey (DHS) which found that child marriage is high (59% of women aged 20-24 years marry before age 18) despite the law setting the age of marriage at 18 years; unmet need for family planning was at 10% which showed a gap in contraceptive-use need; 62% of pregnant women and girls delivered at home and only 42% of the births were attended by trained personnel, illustrated limited access to quality safe motherhood services. The DHS also established that adolescent girls (15-19) have a high fertility rate due to early marriage, early pregnancy and low contraceptive use.<sup>15</sup> The MR programme included interventions for family planning and safe motherhood to address the DHS findings.

The programme design was also informed by findings of several surveys<sup>16</sup> conducted between 2004 and 2017. The studies found that the health facilities providing MR

<sup>15</sup> Bangladesh Demographic and Health Survey, 2014.

<sup>16</sup> The studies referred to are referenced in footnote 22 to 24 below.

services had declined, with 42% of the public and private health facilities expected to provide services not doing so due to social stigma, lack of training, religious concerns and lack of support for staff and lack of space.<sup>17</sup> Some service providers were also not aware of and/or inconsistently applied the legal gestation age cut-off; and had a negative attitude towards MR.<sup>18</sup> Some women conducted a self-managed MR using medication accessed over-the-counter from pharmacies and drug sellers resulting in unsafe abortion. An estimated 128,000 women who needed PAC did not obtain it.<sup>19</sup> The MR programme was designed to provide safe quality MR, MRM and PAC services and contraceptives to the MR and PAC clients among others. Further, the MR programme offered training to government, NGOs and private sector service providers to expand availability of quality of the MR, MRM, PAC and FP services.<sup>20</sup>

The programme design was also informed by feedback from consultations held with government officials, service providers, other like-minded NGOs and clients; and the National SRHR Conference. Based on feedback from these consultations, the programmes introduced the provision of long-term FP methods; RTI/STI management; cervical and breast cancer screening and referral services as well as comprehensive behavioural change interventions for adolescents.<sup>21</sup> In addition, RHSTEP and BAPSA conducted client exit surveys every six months<sup>22</sup> which provided information on client satisfaction with the services offered and identified any unmet SRHR needs. This enabled the MR programme to maintain its focus on the health and SRH needs of the clients during the implementation period. However, the programme did not explicitly identify and/or respond to the needs of women and girls with disability, men and boys and LGTBQI people at design and implementation stages.

## 4.2 EFFECTIVENESS

***EQ E1: Have all the intended target groups including women with disabilities, had access to the services and other deliverables provided through the program?***

The findings under effectiveness are presented for each individual programme output. The evaluation assessed the extent to which intended target populations accessed

<sup>17</sup> Altaf Hossain, Isaac Maddow-Zimet, Meghan Ingerick, Hadayeat Ullah Bhuiyan, Michael Vlassoff and Susheela Singh, 2014. Access to and Quality of Menstrual Regulation and Post-abortion Care in Bangladesh: Evidence from a Survey of Health Facilities; and Susheela Singh, Altaf Hossain, Isaac Maddow-Zimet, Michael Vlassoff, Hadayeat Ullah Bhuiyan and Meghan Ingerick, 2014. The incidence of menstrual regulation procedures and abortion in Bangladesh.

<sup>18</sup> Bonnie Crouthamel, Erin Pearson, Sarah Tilford, Samantha Hurst3, Dipika Paul, Fahima Aqtar, Jay Silverman and Sarah Averbach. Out-of-clinic and self-managed abortion in Bangladesh: menstrual regulation provider perspectives.

<sup>19</sup> Susheela Singh, Altaf Hossain, Isaac Maddow-Zimet, Michael Vlassoff, Hadayeat Ullah Bhuiyan and Meghan Ingerick. 2017. Access to and Quality of Menstrual Regulation and Post-abortion Care in Bangladesh: Evidence from a Survey of Health Facilities.

<sup>20</sup> Interviews with RHSTEP, BAPSA HQ and clinic staff and MoHFW officials

<sup>21</sup> The MR programme document and key informant interviews with RHSTEP and BAPSA staff, and government officials.

<sup>22</sup> The client exit interviews/survey population were clients seeking services at RHSTEP and BAPSA clinics, selected through non-probability sampling frame. Data was collected using a structured questionnaire administered to the selected clients. All ethical considerations were observed including receiving consent from respondents and ensuring all data was kept confidential and only used for the purpose of the study and identities of respondents were kept anonymous.

services and other deliverables. The assessment involved a comparison of the number of people who expected to access services (the targets) against the number that actually accessed services.

**Output 1: Training of service providers and community volunteers training on MR/MRM and other SRHR issues.**

**Finding 2.1.1a: Targets for medical practitioners who received MR/MR training were achieved while targets for FWVs, SACMOs, paramedics, community volunteers and peer educators were achieved to a lesser degree. This notwithstanding, the trained service providers contributed to the increase in availability of MR services in the country.**

Training of service providers, community volunteers and peer educators on MR, PAC and FP was expected to expand availability of safe and quality MR/MRM, PAC and FP services in government, non-governmental organisations (NGOs) and private health facilities. Service providers targeted for training were doctors, nurses, family welfare visitors (FWVs), paramedics and SACMOs. The Directorate General Family Planning (DGFP), identified the service providers to be trained, based on an annual training plan, and apportioned the number of services providers to be trained by the consortium (RHSTEP and BAPSA).

The consortium has a pool of trainers, both internally in RHSTEP and BAPSA and external trainers drawn from DGFP and medical college hospitals among other institutions. A standardised training manual approved by the DGFP was used for training and DGFP, RHSTEP and BAPSA supervised the training. Training was delivered both in theory and practice or simulation and trainees were followed up to the health facilities to assess their confidence and ability to follow the instructions in practice.<sup>23</sup> During this programme period, the consortium acquired innovative modern training equipment used for simulation and practical sessions which made training on MR, PAC and SMH to be more effective.<sup>24</sup>

As shown in Figure 5 below, annual targets for medical practitioners (doctors and nurses) to be trained on basic MR were achieved or even surpassed in all the years except in 2017/2018 when a few (15 out of total of 106) service providers attend the training due to personal reasons.<sup>25</sup> Targets for FWV, SACMOs and paramedics receiving refresher MR training were not achieved except in 2022 because of the unavailability of these service providers due to short notice of the trainings, family problems and an unwillingness to take the training, especially among those nearing retirement age.<sup>26</sup> On the part of community volunteers and peer educators receiving SRH training, a higher number were trained in 2017/18 and 2018/19 while targets from

<sup>23</sup> Safe MR programme annual reports, programme data, training reports and interviews with RHSTEP and BAPSA staff.

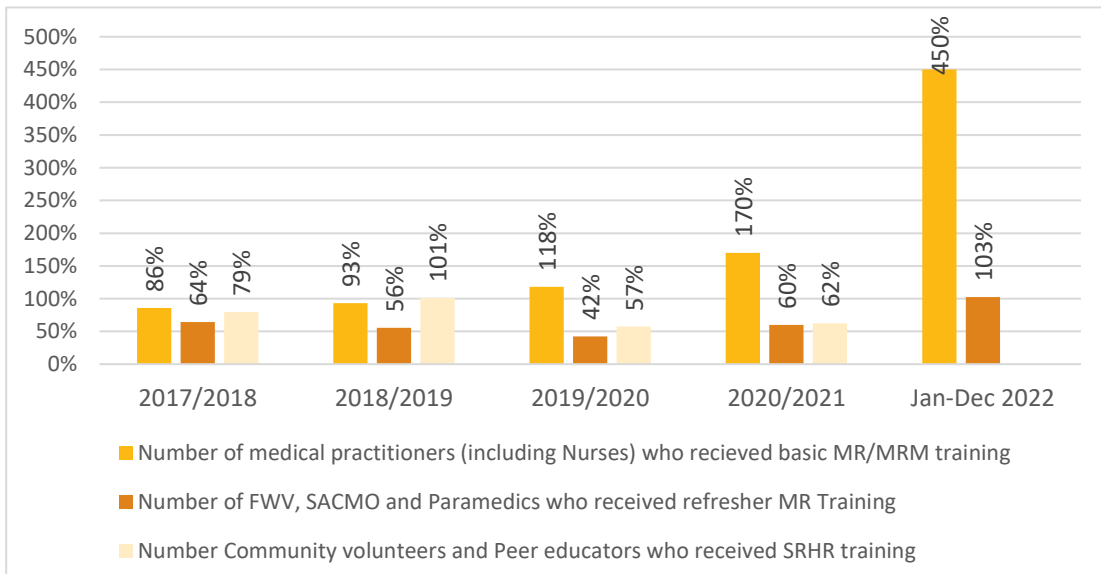
<sup>24</sup> Observation of equipment by the evaluation team.

<sup>25</sup> Safe MR programme annual reports, programme data, training reports and interviews with RHSTEP and BAPSA staff.

<sup>26</sup> Safe MR programme annual reports, programme data, training reports and interviews with RHSTEP and BAPSA staff, NGOs and MoHFW officials.

2020 and 2021 were not achieved due to COVID-19 related travel restrictions. The training of community volunteers and peer educators did not take place in 2022 due to lack of funding.<sup>27</sup>

**Figure 5: Percentage of targeted service providers who received training on MR/MRM and other SRH areas, 2017 to 2022**



The DGFP provided equipment, medicines and other supplies required for the trained service providers to provide MR/MRM services. In addition, DGFP, in collaboration with RHSTEP and BAPSA, made follow-up monitoring and mentorship visits to the trained service providers to assess their level of confidence in applying the skills gained, although this follow up was not regularly undertaken.<sup>28</sup> Data on the number of clients provided MR/MRM services in government, NGOs and private facilities by the trained service providers is not available. However, feedback from key informants<sup>29</sup> shows that MR medicines and supplies provided to government facilities were utilised and the trained services providers provided MR services.

**Output 2: Skills of RHSTEP and BAPSA staff on SRHR service delivery and program management improved.**

**Finding 2.2.1a: Training of the consortium staff in SRH, gender and SGBV, and project and financial management improved staff skills in these areas and contributed to improved programme management and SRHR service delivery.**

RHSTEP and BAPSA staff were trained in a wide range of topics including gender and sexuality, counselling, SRHR, sexual and gender-based violence (SGBV), communication and motivation, research methodology, advocacy and networking,

<sup>27</sup> Safe MR programme annual reports, programme data and interviews with RHSTEP and BAPSA staff at HQ.

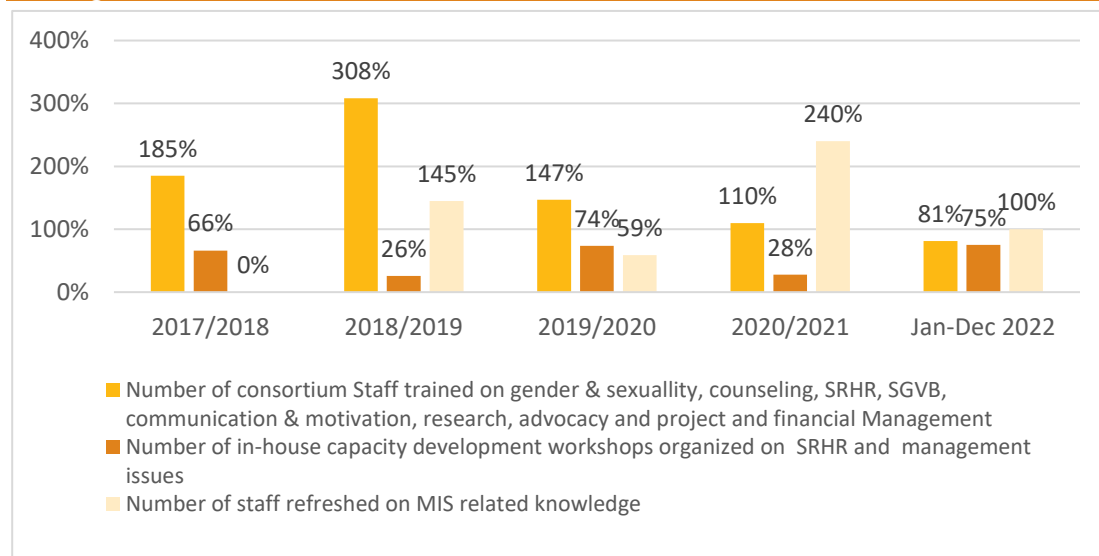
<sup>28</sup> Interviews with trainees and trainers.

<sup>29</sup> Interviews with MoHFW, RHSTEP and BAPSA, trainers and trainees.

project management, financial management and management information systems (MIS). The trainings responded to capacity gaps identified through programme reviews, supervision and audits. Trainings which the consortium did not have internal expertise to deliver were conducted in partnership with external trainers. For instance, SGBV and disability trainings were conducted in partnership One Stop Crisis Centre (OCC) and the Centre for Disability and Development respectively.<sup>30</sup> During COVID-19, the consortium integrated COVID prevention and management guidelines into the trainings offered and followed all the COVID-19 infection prevention protocols.

The number of staff targeted for training was achieved or surpassed in all the years (see Figure 6 below). However, the extent to which the target for the in-house workshops, whose purpose was to update staff skills and share knowledge on SRHR and management issues, was achieved varied from year to year due to staff focusing more on programme activity implementation and staff working from home during COVID-19 pandemic.<sup>31</sup> The target for training staff on the updated MIS training to reporting was also achieved except in 2019/2022 due to the COVID-19 pandemic.

**Figure 6: Percentage of consortium staff trained on SRH, gender and management areas, 2017 to 2022**



The RHSTEP and BAPSA monitoring of SRH service delivery found that clinical staff follow the guidelines and apply skills gained through training. Staff in the clinics are also applying skills gained from the training. For instance, staff have stopped requiring consent from husbands to provide SRH services. Internal audit reports have also shown improvement in financial management and procurement over time. However, internal audits have persistently identified gaps in procurement (advertisement or solicitation of quotations and assessment of bids) and financial management (proper

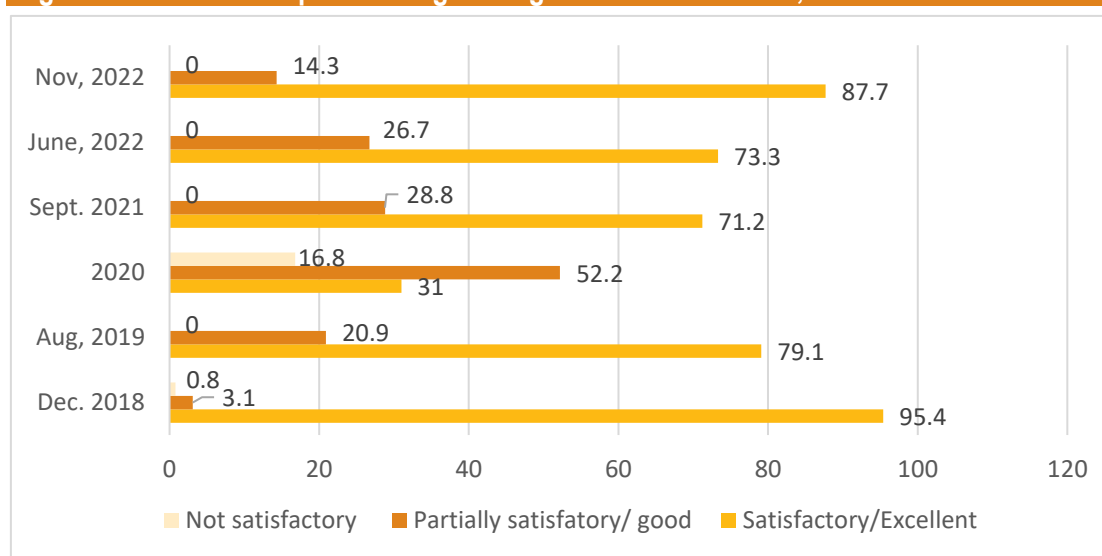
<sup>30</sup> Interviews with RHSTEP and BAPSA staff and external stakeholders.

<sup>31</sup> Safe MR programme annual reports, programme data, interviews with RHSTEP and BAPSA staff at HQ.

documentaiton of vouchers) especially in BAPSA. Staff in the clinics visited demonstrated that they are using the MIS.<sup>32</sup>

Figure 7 below shows the level of client satisfscction with services offered by RHSTEP and BAPSA. A majority of the clients rated the services satisfactory or excellent and good/artially satisfactory. Although clients may not have the ability to assess the clinical quality of services offered, this rating shows a high level of satisfaction with the way clients are handled at the clinics.<sup>33</sup>

**Figure 7: Client's opinion regarding overall services, 2018 t0 2022<sup>34</sup>**



**Output 3: Services rendered to women, men and adolescents on MR and SRH Services from the consortium clinics as needed.**

Under output 3, the programme supported the provision of various SRH services in the RHSTEP and BAPSA clinics. The support was in the form of medicines, equipment and supplies, staff salaries and operational costs. This section details the findings on the extent to which targeted populations accessed services in the clinics.

**Finding 2.3.1a: RHSTEP and BAPSA sustained the pro-poor SRH service delivery by providing free or subsidised services to poor clients, despite charging for services.**

RHSTEP and BAPSA have operated for more than 4 decades providing free MR, PAC and FP services to poor communities. However, due to the need to sustain service delivery, both organisations introduced charges for clients which were considered low compared to charges by other NGOs and the private sector for similar services. However, both organisations have a policy of zero-denial of services to any clients based on the ability to pay. This policy is implemented through subsidising or offering free services to poor clients based on defined criteria. The criteria include the income

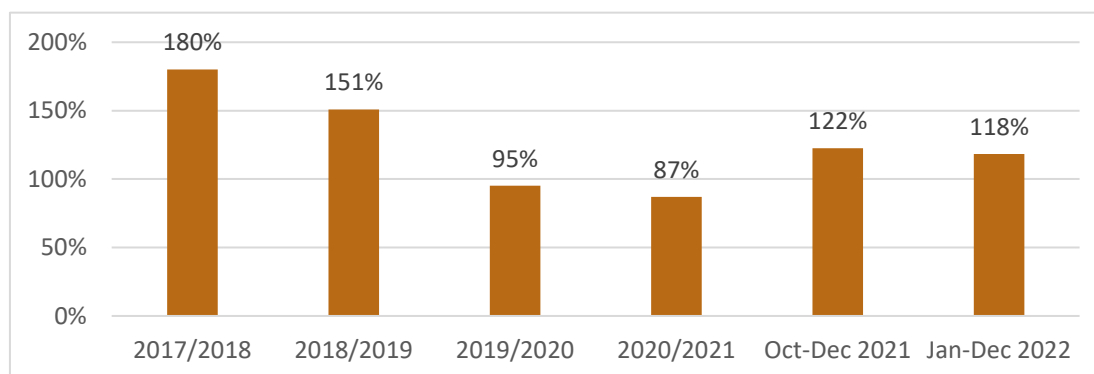
<sup>32</sup> Key informant interviews, internal audit reports and minutes of PAB meetings.

<sup>33</sup> Client exit interviews/ surveys.

<sup>34</sup> Client exit interviews/ surveys.

of the client and the number of family members.<sup>35</sup> Figure 8 shows that targeted number of clients to be offered SRH services free of cost was achieved and even surpassed in all the years.<sup>36</sup>

**Figure 8: Percentage of all services rendered free of cost**



**Finding 2.3.1b: The targets for women and girls receiving MR/MRM services at RHSTEP and BAPSA clinics were to a large extent not achieved and the women and girls accessing MRM has been declining. In addition, there was no specific targeting of women with disabilities.**

Bangladesh allows menstrual regulation (MR) up to 12 weeks. Menstrual regulation (MR) is the one of the core services offered by the consortium. The Figure 9 shows most of the targets for WRA receiving MR/MRM services were less than 70% achieved except in 2018/19 and 2022. The non-achievement of the targets is attributed to barriers such as stigma, cultural norms such as the need for women to be accompanied by their husbands to the health facility, pressure at family level not to seek MR services, low awareness of MR regulations resulting in women seeking these services after 12 weeks, and travel restriction imposed during the different waves of COVID-19 pandemic.<sup>37</sup>

Although RHSTEP and BAPSA does not discriminate any WRA seeking MR and MRM services, both organisations did not have specific approaches for reaching out to women with disabilities, such as through community sensitisation or community outreach services. Further, the data on women provided MR and MRM services was not disaggregated by disability.

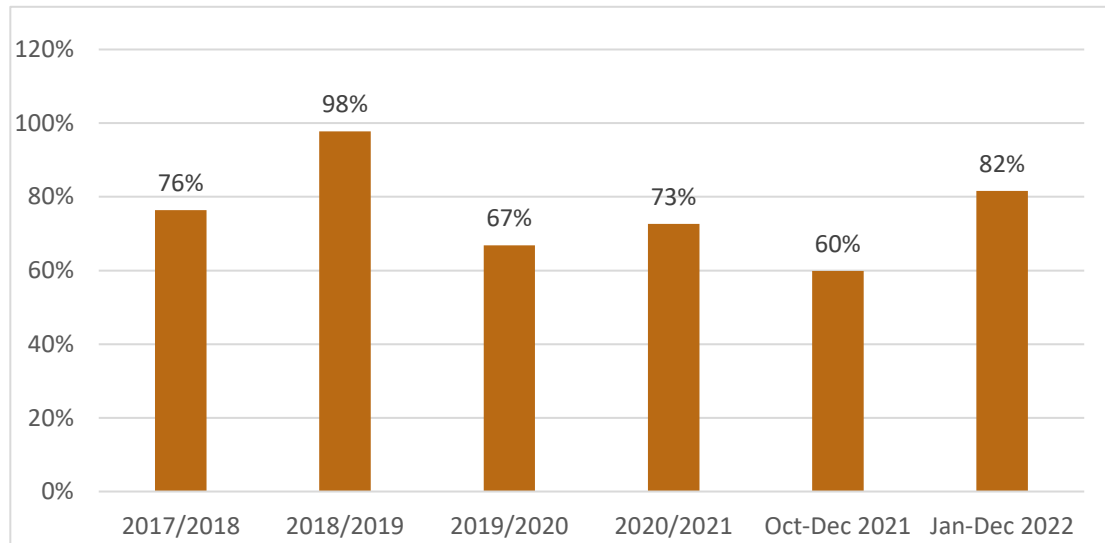
<sup>35</sup> Documents review and key informant interviews.

<sup>36</sup> Programme data.

<sup>37</sup> Programme data, key informant interviews and review of annual reports.



**Figure 9: Percentage of targeted WRA including adolescents and youths received safe MR support (including MRM)**



The targets and results of WRA receiving the MR/MRM services declined over the programme period. Targets declined by 58% between 2017 and 2022 while the results declined by 55% in the same period. The decline is largely due to an increase in the number of women accessing MRM through pharmacies and drug stores.

**Figure 10: Trend in targets and results of WRA receiving MR/MRM services**

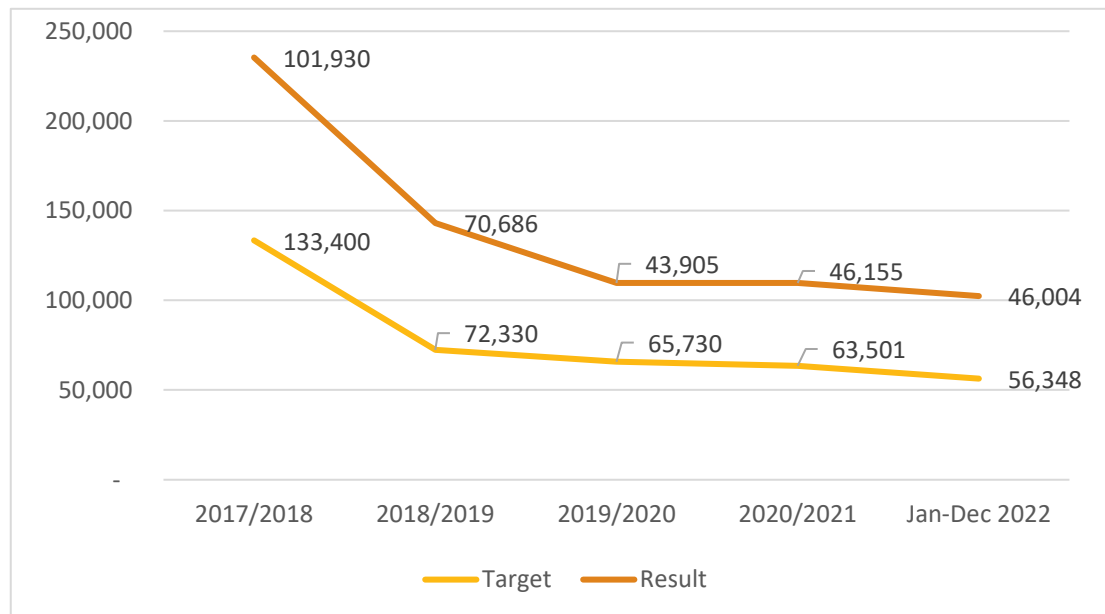
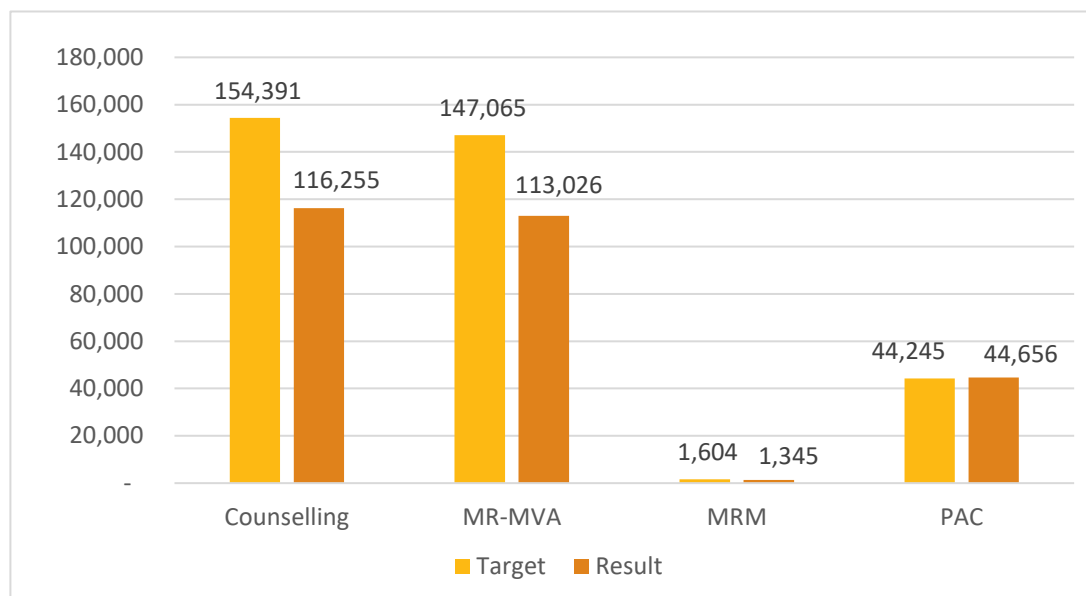


Figure 11 shows that the number of clients provided MRM was low compared to the number provided MR-MVA because women and girls are increasingly seeking MRM through pharmacies. Women seeking MRM through pharmacies are at a high risk of



post-abortion complications which leads to such women seeking post-abortion care (PAC). As shown below, the PAC clients were relatively high at about 44,000.<sup>38</sup>

**Figure 11: Disaggregation of types of MR services: Cumulative results**



**Finding 2.3.1c: Family planning (FP) services were provided in all consortium clinics but uptake was affected by the reduction of the number of clients seeking MRM services and low acceptance of FP among some couples. In addition, there was no specific approaches in place to enable women with disabilities access FP services.**

RHSTEP and BAPSA (the consortium) provide FP methods to clients of MR, MRM, PAC, post-partum mothers and general clients. The DGFP supplies FP methods to consortium and the clinic staff have been trained to offer short and long-acting contraceptives. Information on FP methods is also provided to students in schools, at community level and to garment factory workers to generate demand.<sup>39</sup> Whereas all women seeking FP services at the consortium clinics are served, there was no specific approaches ensuring women with disabilities could access FP services. The data on clients provided FP services is not disaggregated by disability hence it is not possible to analyse the extent to which women with disabilities were provided contraceptives.<sup>40</sup>

<sup>38</sup> Programme data and interviews with BAPSA and RHSTEP and external stakeholders.

<sup>39</sup> Interviews with key informants and annual reports.

<sup>40</sup> Key informant interviews with RHSTEP and BAPSA staff, review of annual report and analysis of programme data.

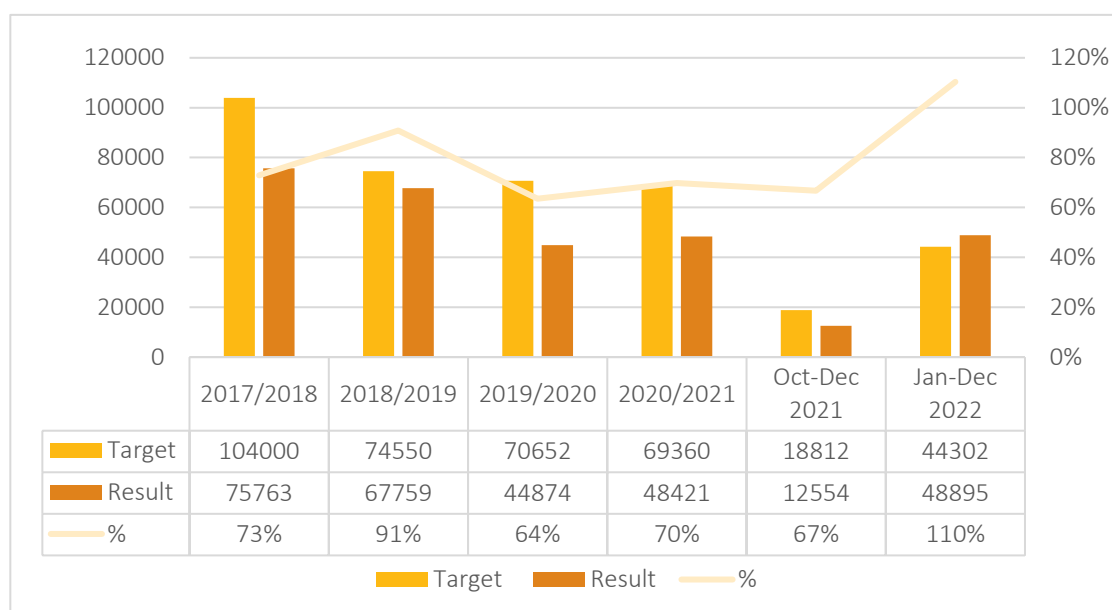
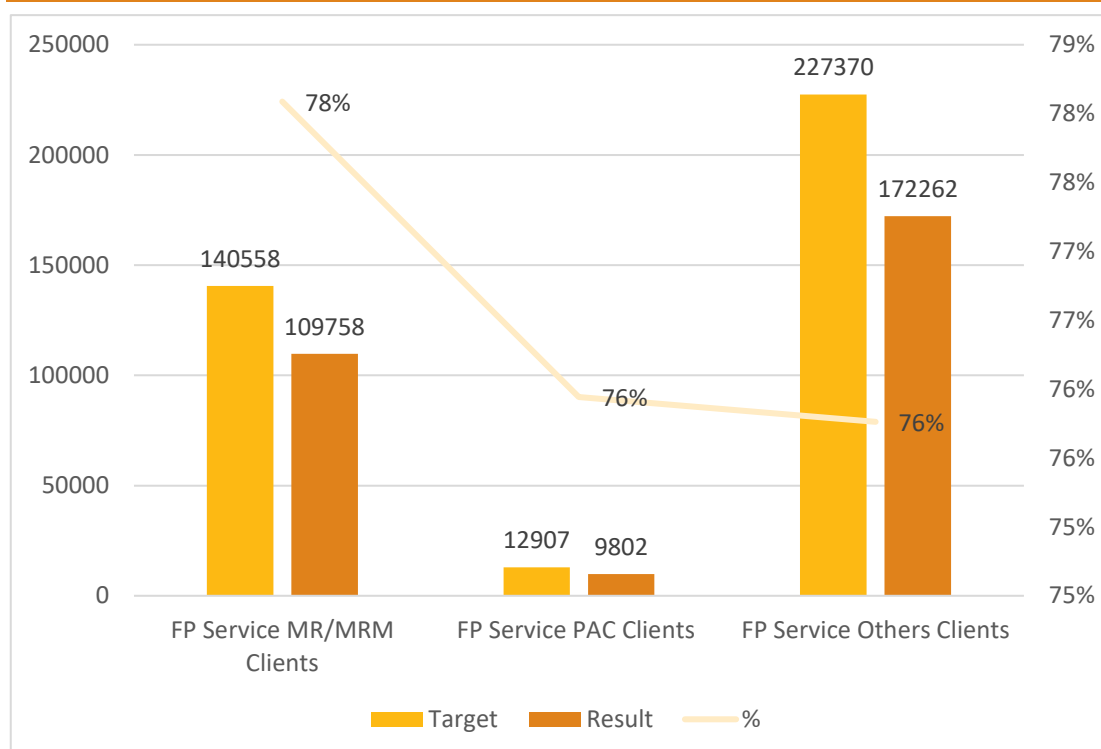
**Figure 12: Number and percentage of targeted clients who received FP method**

Figure 12 shows that: (a) The extent of achievement of the target for clients provided FP methods varies from year to year. Over 90% of the targets for 2018/19 and 2022 were achieved while less than 7% of targets for other years were achieved, partly due to the reduction of MRM clients, challenges facing women in making a decision on contraceptive use at family level and low acceptance of contraceptives among some couples.

Figure 13 shows the provision of family planning by type of client. 78% of the targeted MR/MRM clients, 76% of targeted PAC clients and 76% of targeted general clients were offered family planning services. This underscores the need to intensify awareness and acceptance of FP methods among clients needing MR and PAC.

**Figure 13: Disaggregation of FP services by type of clients: Cumulative results: Cumulative results**



**Finding 2.3.1d: Targets for women provided safe motherhood (SMH) services were achieved due to the high satisfaction with services provided among WRA and clients being referred by relatives, neighbours and relatives. The consortium clinics are largely perceived by clients to be women-friendly. However, no specific approaches were put in place to reach women with disabilities.**

The consortium provides ANC and PNC services in all clinics while deliveries are done in one clinic. The uptake of safe motherhood services is generally high with most of the targets being achieved and/or surpassed<sup>41</sup> due a high level of patient satisfaction<sup>42</sup>; referrals by neighbours, relatives and past clients, and perception of the consortium clinics as being women-friendly.<sup>43</sup> However, programme data is not disaggregated by disability and no specific approaches were made to increase access to SMH services among women with disabilities.<sup>44</sup>

<sup>41</sup> Safe MR Programme annual reports and programme data.

<sup>42</sup> Interviews with key informants, focus group discussions and exit client survey

<sup>43</sup> Reports of the patient satisfaction surveys conducted every six months from 2018 and responses from FGDs for women.

<sup>44</sup> Key informant interviews with RHSTEP and BAPSA staff, review of annual report and analysis of programme data.

**Figure 14: Percentage of targets for WRA receiving Maternal health including safe motherhood services achieved**

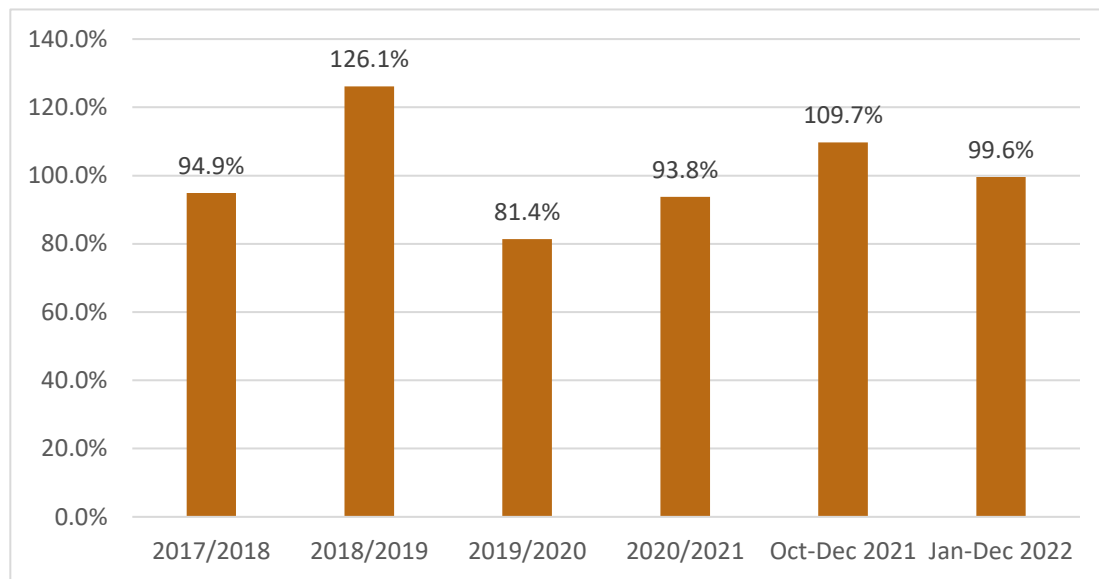
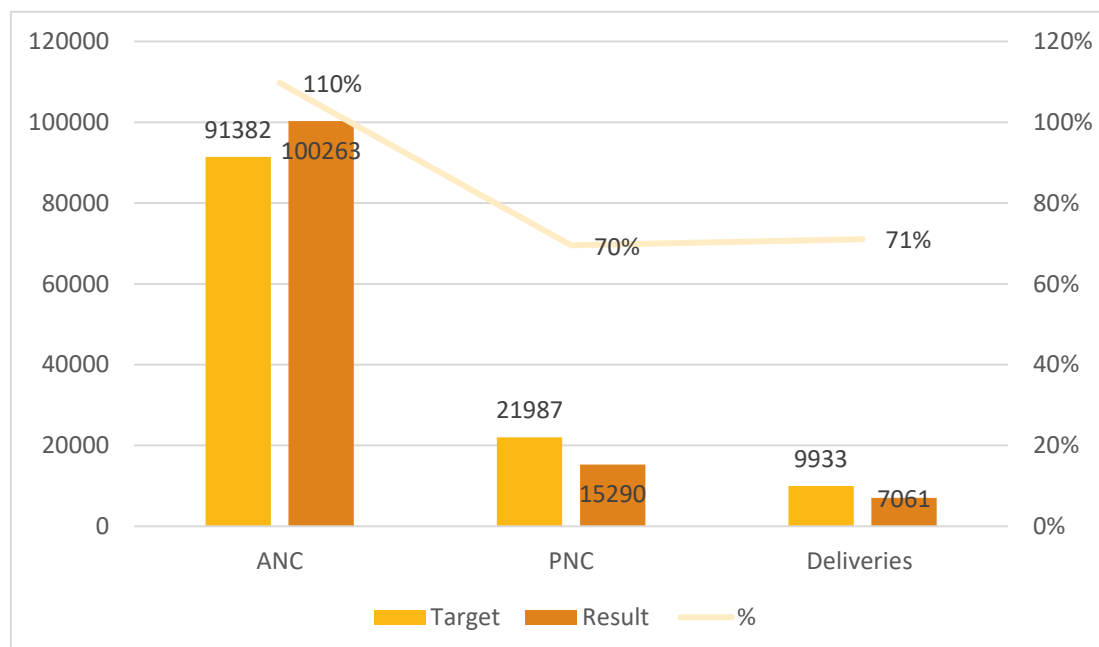


Figure 15 shows the targets and results achieved for women offered different types of safe motherhood services. These are antenatal care (110% of the target achieved), postnatal care (70% of target achieved) and deliveries (71% of the target achieved).

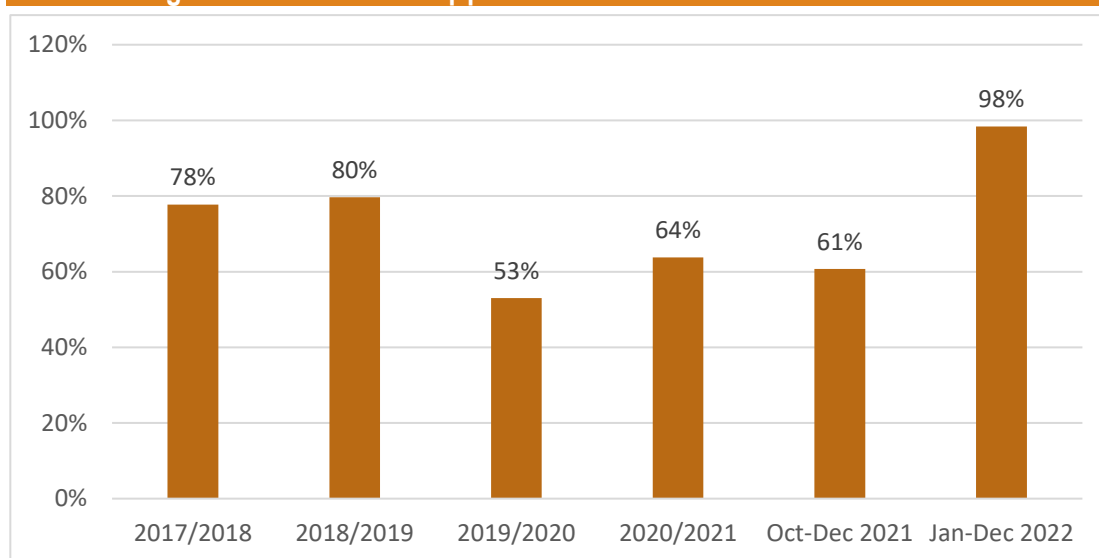
**Figure 15: Types of safe motherhood services provided: Cumulative results**



**Finding 2.3.1e: Targets for the uptake of RTI/STI services were not met in most of the years except in 2022 due to low awareness of RTI/STI among MR, PAC, PAC and SMH clients (and in the community) and the effect of COVID-19 prevention measures. In addition, there was no specific targeting of LGBTQI people and women with disabilities.**

The consortium integrated RTI/STI management in this phase of the safe MR programme. Results show that targets for RTI/STI were less than 80% achieved except in 2022 due to partly due to low awareness about RTI/STI in the community and among clients, and COVID-19 related travel restrictions.<sup>45</sup> The consortium sought to increase RTI/STI awareness by integrating RTI/STI in client education and counselling and in the community SRH awareness. With regard to LGBTQI people and women with disabilities, the consortium did not have approaches for targeting these populations.

**Figure 16: Percentage of the target of females received RTI/STI counselling and treatment support**



**Finding 2.3.1f: There was high uptake of breast and cervical cancer screening among women clients in the consortium clinics. However, low knowledge and awareness on cancer screening among women, especially those in slums and women with disabilities, hindered more women from accessing these services.**

The consortium provided breast and cervical cancer screening in their clinics. Data below shows that there was a high uptake of these services due to increased awareness and acceptance among women clients through the health education and counselling provided in the clinics. Those suspected to have cancer were referred to hospitals for treatment.<sup>46</sup>

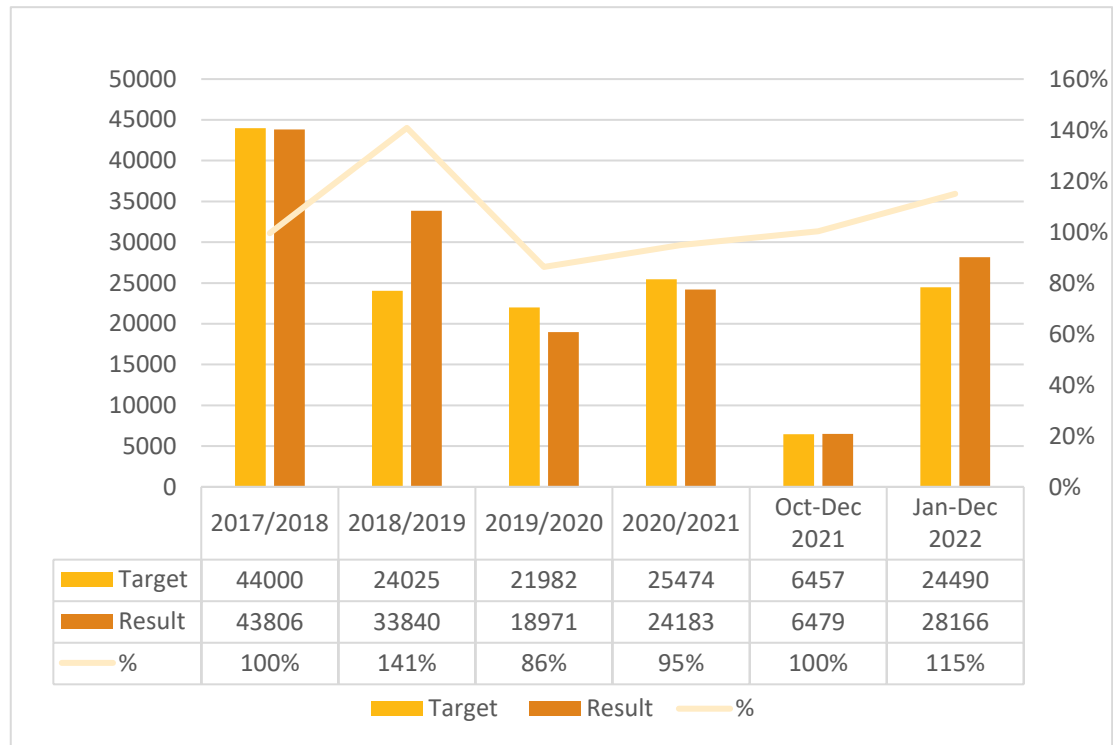
However, there is a low level of breast and cervical cancer awareness among women and girls at community level. For instance, the awareness of cervical cancer among women in slums in Dhaka is estimated at 55%. Further, there was no specific approach to increase awareness on cancer screening among women with disabilities. Thus, the uptake of cervical cancer screening services could have been optimised through the consortium adopting appropriate strategies such as increasing awareness of cervical cancer in the community, taking services to the door step of low-income groups, promoting long-acting family planning methods, increasing male involvement and

<sup>45</sup> Interviews with BAPSA and RHSTEP staff and annual programme reports.

<sup>46</sup> Annual Safe MR Programme reports and programme data.

reducing child marriage.<sup>47</sup> However, the safe MR programme did not initiate these interventions due to limited funding.<sup>48</sup>

**Figure 17: No. of females received reproductive organ cancer screening support**



**Finding 2.3.1g: The introduction of the limited curative care (LCC) during this phase of the programme was considered an innovation in responding to demand from clients. Over 75% of the targets for LCC were achieved except in 2020 and 2021 due to COVID-19 pandemic.**

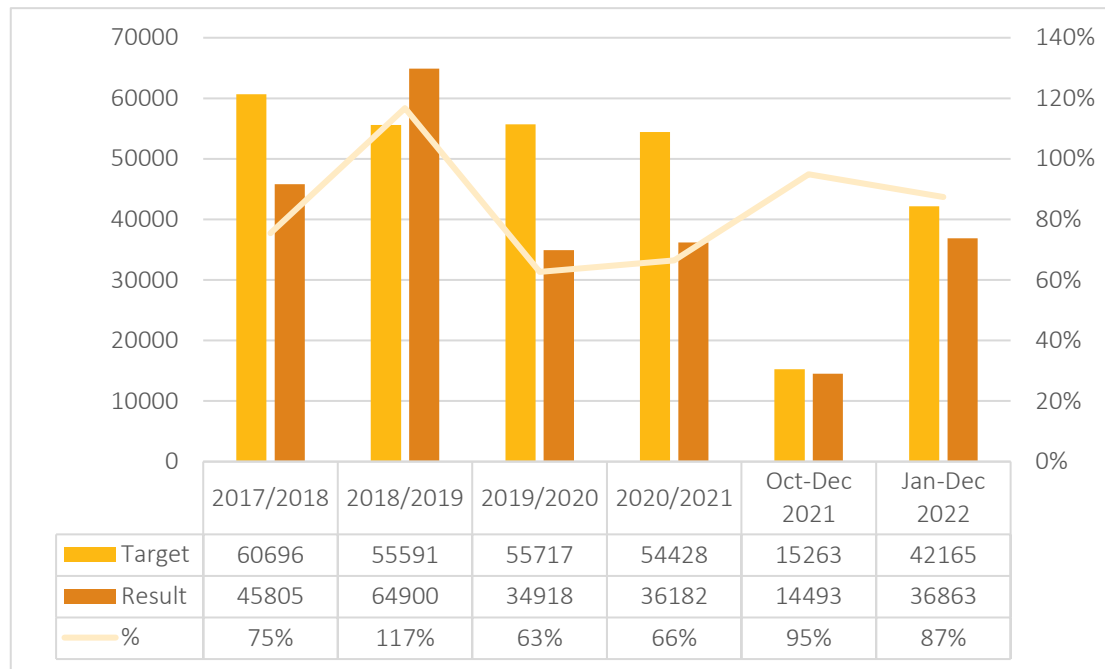
The limited curative service (LCC) was an innovative service introduced in this phase of the programme to respond to demand from the community. The services offered include family planning counselling and services, symptomatic treatment of RTI/STI and ANC and PNC services to adolescents and young mothers as well as pathological services.

Doctors and paramedics (who were mainly female) visited garment factories, schools and communities to offer information and treatment and also referred cases that needed further investigation to RHSTEP and BAPSA clinics. Figure 18 shows that over 75% of the targets for LCC were achieved except in 2020 and 2021 largely due to the effect of the COVID 19 pandemic.

<sup>47</sup> RHSTEP, 2020. Cervical cancer prevention among slum women in Dhaka City: A cross-sectional study.

<sup>48</sup> Key informant interviews with BAPSA and RHSTEP staff at HQ and clinics.

**Figure 18: No. of females including youths and adolescents received LCC support in clinics**

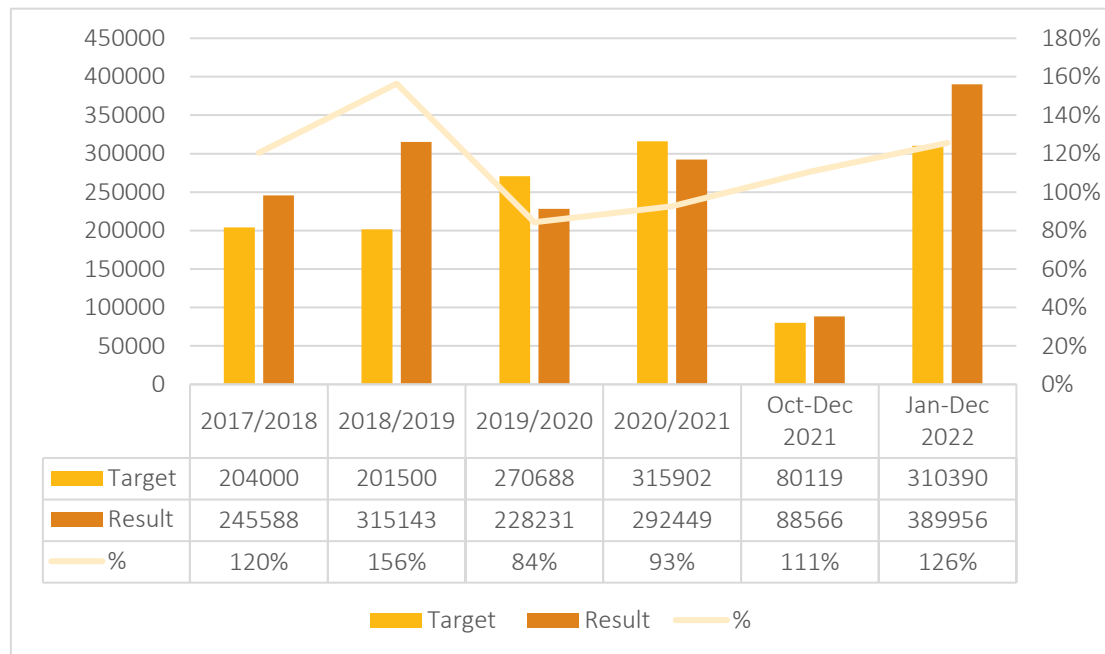


**Finding 2.3.1h: The programme support for pathological services contributed to improvement of the quality of services provided in the consortium clinics. The pathological services were mainly offered to WRA; there was less focus on men and boys while there was no specific targeting of women with disabilities and LGBTQI people.**

Both BAPSA and RHSTEP provide a wide range of pathological services related to SRH including blood test, urine test and ultrasonogram. The organisations invested in pathology by equipping laboratories with equipment and commodities to undertake SRH related tests. Targets for diagnostic services were met and even surpassed in all the years except in 2019/2020 when the COVID-19 pandemic affected service uptake. Hospital authorities also often referred clients for diagnostic services in the RHSTEP clinics.<sup>49</sup> However, few men and boys were offered pathological services (especially RTI/STI investigation). The men reached were those who accompanied female partners to the clinics. There was also no specific targeting of women with disabilities or LGBTQI people.<sup>50</sup>

<sup>49</sup> BAPSA and RHSTEP staff interviews and review of annual programme reports.

<sup>50</sup> Key informant interviews with RHSTEP and BAPSA staff, review of annual report and analysis of programme data.

**Figure 19: Number and percentage of clients received diagnostic services**

**Finding 2.3.1i: The provision of SRH services in schools, garment factories and at community level underperformed due to the slow start of this intervention, COVID-19 pandemic and limited funding.**

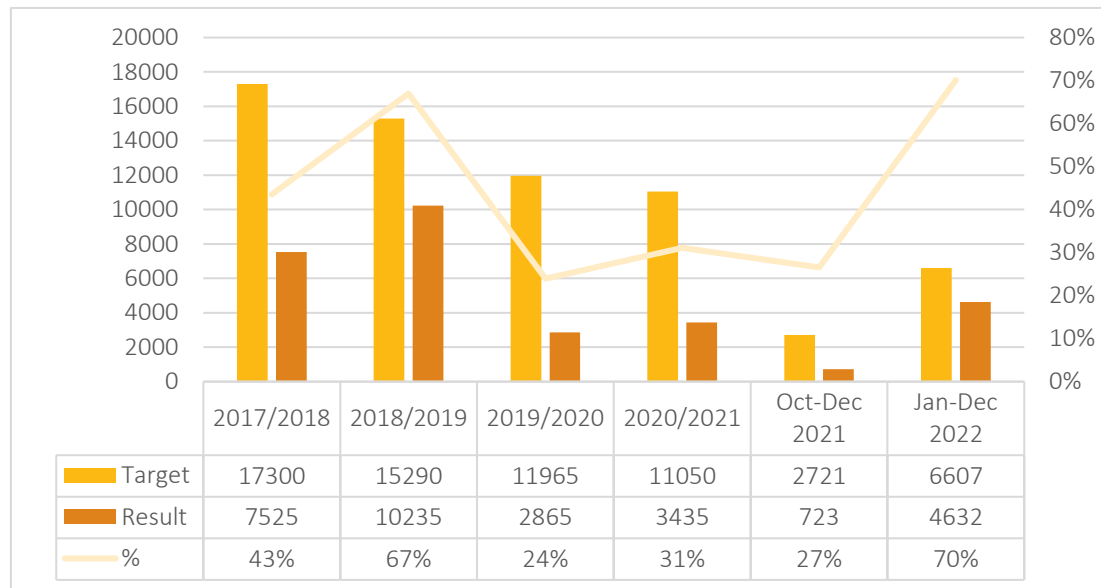
The programme supported the provision of LCC and SRH services to women and adolescents in garment factories and schools and at the community level. Figure 20 shows a very low level of achievement of the targets for this intervention for various reasons. First, the prolonged wait for approval from the NGO bureau in 2017/2018 meant that there was less time to provide services to schools, community and garment factories. In 2018/2019, schools and garment factories rescheduled and postponed dates for service camps due to school examinations and coinciding dates with shipment deadlines for garment factories. In 2019 to 2021, the various waves of the COVID-19 pandemic led to the closure of schools and mobility restrictions which hindered provision of services in the community and at garment factories. In 2022, schools were more focused on recovering lost learning time from the pandemic resulting in non-achievement of the targets.<sup>51</sup> The reduction of funding for this component especially from 2019/2020 also contributed to the low performance of the programme. There were funding constraints to have counsellors (supported by clinical staff in some cases) visit communities, schools and garment factories. Staff to conduct outreach activities are also inadequate. For instance, in some clinics visited, there were only one or two counsellors, who could not conduct outreach activities while also attending to clients at the clinic.<sup>52</sup>

<sup>51</sup> Programme annual reports, programme data and key informants with consortium staff.

<sup>52</sup> Human resources data; key informant interviews with clinic staff and interviews with school teachers, garment factory workers and community support groups; and programme annual reports and programme data.



**Figure 20: No. of adolescents received SRH services in schools, community and garments factories**



**Finding 2.3.1j: The use of the mobile phone to provide SRH services was an innovation introduced during this programme. Although the targets for mobile services were largely over-achieved, the absolute number of people reached through mobile services was relatively small.**

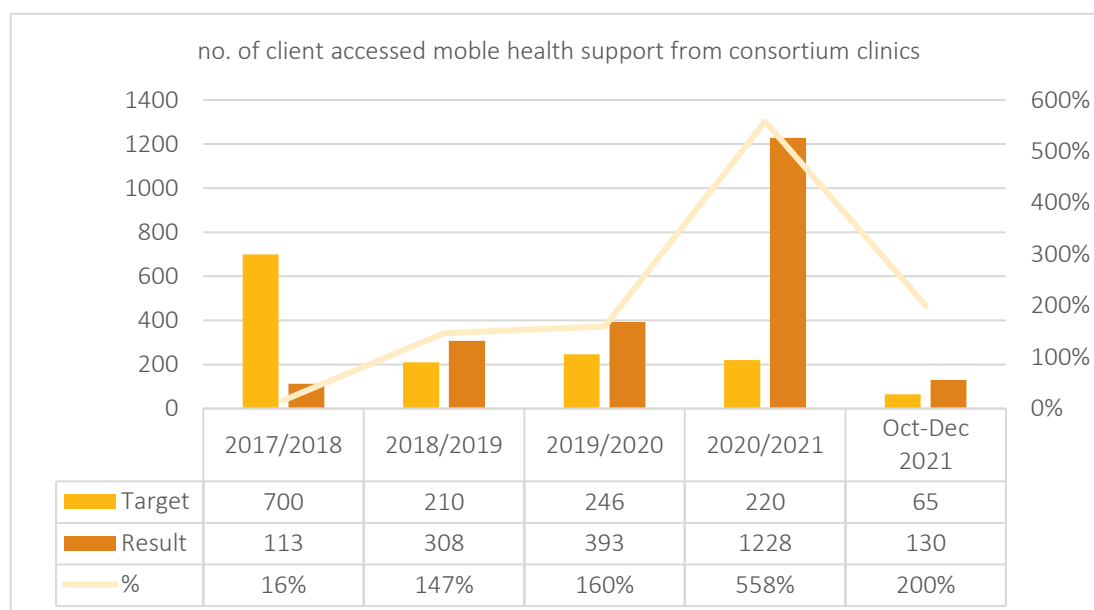
The use of the mobile phone is an innovative approach to improving efficiency in providing SRH services, addressing stigma and confidentiality related to clients physically visiting the clinics. In addition, following up on clients through mobile phones improves the quality of services by ensuring clients are following instructions given by clinicians.<sup>53</sup>

The provision of SRH services through mobile telephone had a slow start in 2017/18 when only 16% of the target was achieved. In the subsequent years, the targets for mobile services were overachieved partly because the targets were downscaled as indicated in the figure below. In 2020/2021, there was a spike in the number of clients provided services through the mobile phone because most clients could not visit the clinics during the COVID-19 pandemic.<sup>54</sup> However, although the targets have largely been over-achieved, the absolute number of people reached show low use of mobile services because most cases needed a physical examination and pathological investigation.<sup>55</sup>

<sup>53</sup> Interviews with RHSTEP and BAPSA staff at HQ and in the clinics.

<sup>54</sup> Annual programme reports and programme data and interviews with consortium staff.

<sup>55</sup> Analysis of programme data.

**Figure 21: Number and percentage of client reached through mobile phones**

#### **Output 4: Women, men, and adolescents received information on SRHR.**

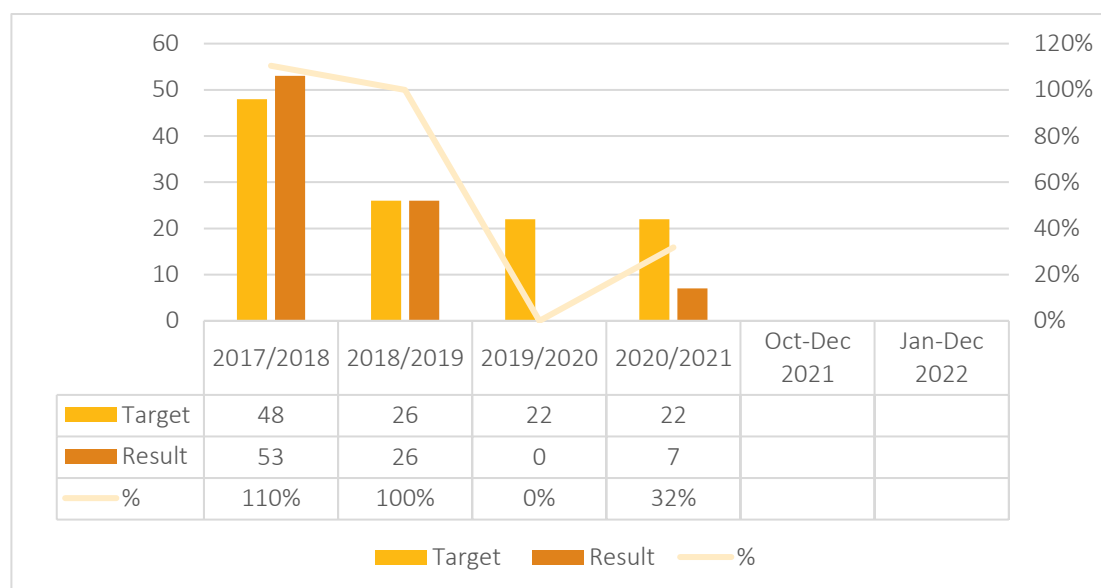
**Finding 2.4.1a: Programme activities contributed to an increase of SRH knowledge and awareness among women, men, girls and boys in years 1 and 2, after which the activities were scaled down. The activities also did not target women with disabilities and LGBTQI people.**

The programme reached women, men, girls and boys with SRHR information through sessions held at schools, garment factories, Alodhara Patshala and community level in years 1 and 2. The activities were scaled down from year 3 due to funding limitations. However, these activities did not specifically target women with disabilities. Furthermore, a limited number of LGBTQI people participated in the Alodhara Patshala activities despite the consortium not having specific approach for reaching out to this group.

#### **SRHR sessions at community level for WRA and adults**

Targets for WRA and adults provided with SRHR information (including MR, PAC, FP, SMH etc.) were achieved in year 1 and 2. The targets were not achieved in years 3 and 4 after which activities were stopped due to the effect of COVID-19 and limitations in funding. Therefore, the contribution of the programme to improving SRHR awareness were only significant in years 1 and 2.<sup>56</sup>

<sup>56</sup> Safe MR Programme data and interviews with RHSTEP and BAPSA staff.

**Figure 22: No. session organized at communities for WRA and other adults**

#### Establishment of youth friendly corners

Another implementation modality for increasing SRHR knowledge among adolescents and young people was through establishing Arodhara Patshalas to provide a safe space for adolescents and young people to access SRHR information. Four Arodhara Patshalas were established by 2019 and sustained throughout the programme period.<sup>57</sup> The participants in these centres included boys, girls and LGBTQI people. These participants demonstrated in-depth knowledge and confidence in articulating SRHR issues. They also disseminated the same information to their siblings, parents and friends which shows the multiplier effect of this intervention.<sup>58</sup>

#### Adolescent fairs

The programme organised 8 youth fairs and conferences to disseminate SRHR information through debates, drama and other edutainment games. Adolescent fairs were organised for adolescents in the school and the community.<sup>59</sup> In addition, behaviour change communication materials on FP, breast cancer, MRM, and SMH stickers were distributed to reach about 108,150 people in the community<sup>60</sup>.

The table below shows the extent to which the targeted women, men and adolescents were reached.

<sup>57</sup> Combined Yearly Report (OCTOBER 2017-SEPTEMBER 2018). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

<sup>58</sup> Combined Yearly Report (2019-2020). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

<sup>59</sup> Safe MR Programme data and interviews with RHSTEP and BAPSA staff.

<sup>60</sup> Combined Yearly Report (OCTOBER 2017-SEPTEMBER 2018). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

**Table 4: Number of women, men, and adolescents received information on SRHR- Targets vs Results**

Output 4: Women, men, and adolescents received information on SRHR									
	No. of adolescent fair organised			No. of Youth Friendly corner established in Dhaka and continued the whole project period			No. of session organised at communities for WRA and other adults		
Year	Target	Result	%	Target	Result	%	Target	Result	%
2017/2018	7	8	114%	5	0	60%	48	53	110%
2018/2019	7	7	100%	4	4	100%	26	26	100%
2019/2020	6	4	17%		4		22	0	0%
2020/2021	3	0	0%				22	7	32%
Oct-Dec 2021									
2022	0	2							

**Output 5: Strengthening of research, monitoring and supervision, and oversight of the programme.**

**Finding 2.5.1a: Programme monitoring and supervision, and oversight were strengthened and this contributed to improved programme implementation. However, utilisation of research findings and recommendations was hampered by lack of funds.**

Annex 7 shows the results of the support provided by the programme in strengthening M&E, management and oversight and research.

### Research

Research on various SRH related topics was undertaken as planned. Research carried out included client exit surveys;<sup>61</sup> cervical cancer prevention;<sup>62</sup> gaps and barriers for SRHR, MR and post-abortion care;<sup>63</sup> and the impact of climate change on SRHR.<sup>64</sup> Whereas these studies provided critical findings and recommendations, the utilisation or implementation of the recommendations was limited due to lack of funds. For instance, cervical cancer research identified barriers hindering women in slums in Dhaka from accessing cervical cancer screening services and recommended the raising of awareness and taking services to the door-step, but these recommendations could not be implemented due to lack of funds. The research on the impact of climate change

<sup>61</sup> RHSTEP, exit interview surveys done every six months since 2018.

<sup>62</sup> RHSTEP, 2020. Cervical cancer prevention practice among slum women in Dhaka City: A cross-sectional study.

<sup>63</sup> RHSTEP, 2022. Gaps in perception in SRHR, barriers to safe MR and post abortion care services and related gender-based violence in young women in Dhaka slums: a comprehensive study.

<sup>64</sup> RHSTEP, 2022. Exploring the impact of climate change on sexual and reproductive health rights programmes and services for the adolescents and women in Bangladesh.

on SRH was not conclusive and recommended further research to better understand the link between climate change and SRHR. Research on gaps and barriers to accessing MR, PAC and SGBV services among young women in Dhaka made recommendations, some of which were in line with the activities of the Safe MR Programme such as addressing unmet need for family planning, and training staff on MR and PAC. However, other recommendations (undertaking SRH education at community level, awareness campaign to end child marriage, regulating pharmacies in offering MR medicine and integrating mental health into PAC services) required additional financial resources to be implemented.

#### Monitoring and supervision

Field monitoring and supervision was undertaken to assess progress in implementation and identify any gaps that needed to be addressed.<sup>65</sup> Issues identified during the monitoring visits were communicated in writing to the clinic manager to act and the actions taken were reviewed during the follow-up supervision visit.

#### Programme oversight

The consortium held monthly, quarterly and annual meetings both at the head office and in the clinics to review programme implementation and service delivery. For instance, the Project Advisory Board convened meetings to review progress of the programme, finalise annual work plans and budgets, and address any emerging issues<sup>66</sup> arising from monitoring and supervision, internal audit, financial and procurement reports. The Executive Committee (EC) meetings were also held to provide strategic direction and review programmatic and financial reports for accountability.<sup>67</sup> Internal audits were conducted and issues identified were presented to the Executive Director for action.<sup>68</sup> However, the Technical Advisory Committee was not constituted because the consortium was member of the National MR and MRM Alliance, the National Technical Committee of Long Acting Reversible Contraceptives and the Technical Committee of Obstetrical and Gynaecological Society of Bangladesh (OGSB) which played the role that the technical advisory committee could have played.<sup>69</sup>

**Output 6: Advocacy strengthened through network, coordination, issue-based seminars and national and international days observation with local and national health and other authorities.**

#### **Finding 2.6.1a: The contribution of advocacy activities to strengthening of SRH policy, and increase of SRH awareness and demand for SRH services was limited because the**

<sup>65</sup> The consortium has a monitoring checklist for capacity building and service delivery used for monitoring service delivery in the clinics.

<sup>66</sup> Examples of issues addressed by the PAB include delay in establishment of MIS and the inventory management system; few instances where procurement procedures were not followed to the letter, addresses issues identified by internal audits such as lapses in following internal controls such as signing of vouchers etc; and implementation challenges during the COVID-19 pandemic.

<sup>67</sup> Safe MR Programme data and interviews with RHSTEP and BAPSA staff.

<sup>68</sup> Internal audit reports from 2018 to 2023 and interviews with RHSTEP and BAPSA staff.

<sup>69</sup> Interviews with RHSTEP and BAPSA staff at HQ and clinics show that equipment and logistical support were provided to the clinics.

**policy agenda was not well defined, activities lacked post-event action plans and some activities were one-off events.**

#### Network

The output targets for network events organised with like-minded organisations on SRHR issues were achieved (Table 5). Networking meetings were held with the community including leaders, women and men. However, the issues advocated for during these meetings and what the meetings achieved is not evidence.<sup>70</sup> There were no post-meeting action plans to follow up on issues discussed.

#### Seminars and workshops

118 seminars and workshops on SRHR were held during the programme implementation period (Table 5); but the contribution of these meetings to SRHR advocacy is not evident.<sup>71</sup>

#### Talk-shows

The programme was expected to support dialogue and talk shows in eminent electronic media. However, the contribution of this activity to SRH advocacy was minimal as only one talk-show was held with MR experts.<sup>72</sup>

#### Observation of national/international days

The days observed during the programme implementation period included World Population Day, Family Planning Week<sup>73</sup> were celebrated, in 2018/2019 - World Population Day, World AIDS day,<sup>74</sup> Safe Motherhood Day, International Women's Day, World Health Day, National Immunization Day, Breast feeding week, Human Rights Day and Menstrual Hygiene Day. The celebrations of these days were held both at national and district levels government and other stakeholders.<sup>75</sup> The observation of these days provided visibility to the MR, PAC, FP, cervical cancer and other SRH issues but there were no post celebration action plans and concrete contribution to the advancement of SRH policy.

#### "Health & Rights" newsletter

The planned newsletter publication was not done. This activity could have provided visibility to the programme results, increased awareness of services provided in the

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<sup>70</sup> Review of programme annual reports and interviews with RHSTEP and BAPSA staff.

<sup>71</sup> Interviews with BAPSA and RHSTEP step and review of annual programme reports.

<sup>72</sup> Analysis of programme data.

<sup>73</sup> Combined Yearly Report (October 2017-September 2018). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

<sup>74</sup> Combined Yearly Report (OCTOBER 2018-SEPTEMBER 2019). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

<sup>75</sup> Combined Yearly Report (OCTOBER 2019-SEPTEMBER 2020). Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project).

consortium clinics, increased awareness of the importance of MR, and reduce misconceptions on MR and PAC services.

**Coordination with local health and other authorities:** A large number of coordination meetings were with the local health and other relevant authorities to enable local government authorities to understand and raise awareness on MR and other SRH issues. However, a clear plan for post meeting action was lacking.

**Community support group meetings:** A limited number of community support meetings were held especially from 2019/2020 to 2022 (Table 5) to effectively increase awareness and remove social- cultural, religious and family level barriers to accessing MR, FP, PAC and other SRH services.

**Youth conferences and festivals:** Only 1 youth conference was held by RHSTEP<sup>76</sup> and only one youth festival was organised in Dhaka by BAPSA. These events were on-off and did not adequately contribute to the increase of SRHR awareness and demand for SRH services among young people.<sup>77</sup>

**Table 5: Output targets against achieved results**

Output-6: WBS-600: Advocacy strengthened through 2734 network meetings, coordination meetings with local and national health and other authorities, issue-based seminars, national and international days observation organised at central and local level with different stakeholders												
	No. of Network meeting organised with like-minded organisations on SRHR issues			No. of Seminar/Workshop on SRHR issues organised			No. of dialogue and talk shows will be organised with eminent print and electronic media on SRHR issues			No. of national/ international day observed at national and local level		
	Target	Result	%	Result	Target	%	Target	Result	%	Result	Target	%
2017/18	10	8	80%	31	28	90%	0			128	84	66%
2018/19	8	8	100%	31	30	97%	0			106	60	57%
2019/20	7	6	86%	30	22	73%	1	0	0%	95	24	25%
2020/21	7	7	100%	29	25	86%	0			1	0	0%
Oct-Dec 2021												
2022	8	7	88%							25	31	124%
	No. of Coordination meeting participated with local health and other authorities concerned			No. of community support group meetings organised			No of youth conferences organised			No of youth festivals organised		
	Target	Result	%	Target	Result	%	Target	Result	%	Result	Target	%

<sup>76</sup> This was a youth conference held in Sylhet for young people drawn from several districts.

<sup>77</sup> Annual programme reports and interviews with consortium staff.

2017/18	648	689	106%	15	14	93%						
2018/19	394	333	85%	6	5	83%	0	1		1	1	100%
2019/20	324	231	71%	13	3	23%	1	0	0%			
2020/21	256	102	40%	4	1	25%						
Oct-Dec 2021												
2022	224	381	170%									

Key: Green: Over 75% of target achieved, Yellow: Between 50 and 74% of target achieved and Red less than 49% of target achieved

### Output 7: Sustainability of the pro poor and quality MR and PAC programme and SRHR consortium.

**Finding 2.7.1a: The safe MR Programme supported activities aimed at improving RHSTEP and BAPSA capacity and strategies to sustain MR, PAC and SRH services delivery but the support did not go far enough to ensure sustainability.**

With support of the Safe MR Programme, the consortium participated in the national technical (NTC), Coordination Committee of MR Agencies in Bangladesh (CCMRAB) and MoHFW meetings. The consortium participated in a few of these meetings in the first two years and in the last year of the programme. In addition, the consortium held two advocacy meetings with DGFP in 2021 which affirmed the continuation of the training of government service providers on MR, FP and PAC, increased the number of training venues for the consortium and agreed to joint monitoring to follow up service providers after training; and continued cooperation hosting of the RHSTEP clinics in public hospitals. DGFP also integrated consortium into the MoHFW breast and cervical capacity building programme for government service providers.

These activities were expected to integrate the consortium MR programme into the health system. However, the status quo has not changed – the consortium programme maintains its support by government, continues to support the government MR/FP and PAC, cervical and breast cancer training programme and the government continues to provide FP commodities programme. Feedback from key informant interviews show that government support for the consortium MR programme to some extent depends on the MoHFW leadership in place. The government cooperation with and support for the consortium MR programme can change if unsupportive MOHFW leadership were to be in place. Secondly, there is no possibility that government can fund the consortium MR programme.<sup>78</sup>

The consortium held review meetings with development partners at least annually during the programme period. The aim was to use these meetings to mobilise funding.

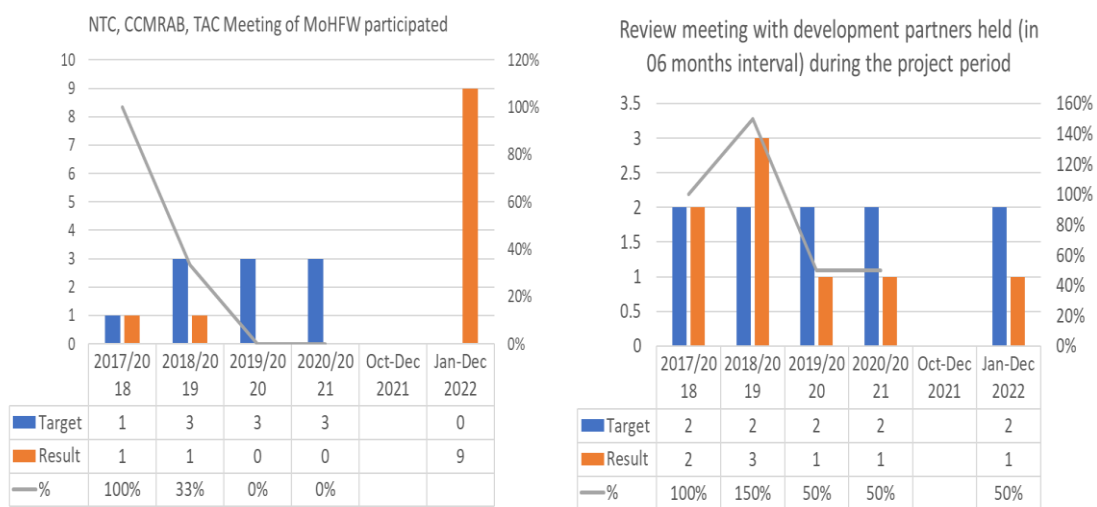
<sup>78</sup> Interviews with MoHFW, RHSTEP and BAPSA.



However, the donor base in Bangladesh is small and the number of donors prioritising support for MR and PAC are even fewer.

RHSTEP and BAPSA established training centres in their head-offices but the plan to establish a full-fledged training centre as one the key strategies for sustainability has not materialised. Other steps taken towards sustainability included the development of the RHSTEP and BAPSA strategic plans which aimed at implementing strategies geared towards sustainability of the organisations.<sup>79</sup> However, the two organisations rely on donor funding and income from the clinics to implement the strategic plans, which is inadequate.

**Figure 23: Output 7 indicator achieved results against targets**



***EQ E2: Are there any factors which prevented target groups from accessing the MR, PAC and other SRH services and training?***

**Finding 2.7.2a: Social-cultural norms and practices, religious beliefs, low awareness and knowledge of SRHR, easy access of MR medicines from pharmacies and drug stores, and clinic/hospital related barriers prevent women and girls from accessing MR, FP and PAC services.**

Social-cultural norms and practices: Menstrual regulation and abortion are taboo not to be discussed or carried out and are highly stigmatised. Secondly, Bangladesh is a patriarchal society where men make decisions for the family. This disempowers women from deciding to access MR, FP and other SRHR services without concurrence of the husband and by extension the family, especially the mother-in-law, who serve as gatekeepers.<sup>80</sup> In addition, women residing far from health facilities, especially in rural

<sup>79</sup> Interviews with BAPSA and RHSTEP including the clarifications provided and the review of annual programmes reports.

<sup>80</sup> Interviews with RHSTEP and BAPSA staff at HQ and clinics, MoHFW officials and NGOs; FGDs with women, adolescent girls, men, community support groups and community women groups.

areas, must be accompanied the husband or family member. Thus, women have to seek consent to have their husbands accompany them.<sup>81</sup>

**Religious beliefs:** MR and PAC are viewed as going against religious believes. Most Muslim religious leaders do not support MR and FP which creates a conservative environment that works against women accessing these services.<sup>82</sup>

**Low awareness about SRHR:** Women and communities have low knowledge about MR, especially regarding the fact that this service is legal, available and allowed within a certain period. Consequently, some women do not seek MR services or they seek the service after the allowed duration has elapsed. SRHR knowledge is also low among boys and girls. The provision of SRHR information in schools has low coverage. The government has integrated some aspects of sexuality education in the curriculum but this is not comprehensive; it only a few SRH issues such as menstrual hygiene, family planning and antenatal care; and teachers have not been adequately prepared to teach sexuality education.<sup>83</sup>

**Unacceptability of FP among some women:** Despite the contraceptive prevalence rate being 64% in the country, there are women and couples who have low acceptance of FP and hence do not take up FP services. These women/couples tend to end up with unwanted or unintended pregnancies after which they seek MR services. The view of the Government of Bangladesh is to first emphasise FP uptake in order to prevent or reduce the need for MR and PAC.

**Clinic/hospital related barriers:** These barriers include (a) working hours for most health facilities, (including RHSTEP and BAPSA clinics) do not accommodate employed women who can only access services after working hours.<sup>84</sup>(b) Brokers who divert clients from clinics to informal or private sector facilities, thus hindering then from receiving quality MR and PAC services.<sup>85</sup> (c) Lack of adolescent friendly in some facilities such as private space and positive attitude healthcare worker attitude. As a result, girls fear accessing SRH services because they might meet relatives. (d) MR and FP services are not allowed for unmarried women. (e) Some women and girls are not aware of the services provided by BAPSA and RHSTEP clinics, with most clients learning about these services from relatives, neighbours and friends<sup>86</sup>

**Access to MRM through pharmacies and drug stores:** MR medicines are available in pharmacies and drug stores but these outlets do not provide adequate instructions on how to use the drugs, when to use them and what to do in case the medicine doesn't work or in case of adverse events. Those who purchase MRM from pharmacies are, sometimes, not intended users and therefore have to pass the instructions to the client.

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<sup>81</sup> Interviews with BAPSA and RHSTEP staff at clinics.

<sup>82</sup> Interviews with RHSTEP and BAPSA staff at HQ and clinics, teachers and students, FGDs with women, and adolescent girls.

<sup>83</sup> Interviews with RHSTEP and BAPSA and school teachers.

<sup>84</sup> Patient satisfaction/ exit interview surveys and key informant interviews.

<sup>85</sup> Interviews with BAPSA and RHSTEP staff.

<sup>86</sup> Patient satisfaction/ exit interview surveys and key informant interviews.

Consequently, the number of women seeking MR in hospitals is declining while cases of incomplete MR and PAC are increasing.<sup>87</sup>

Limited integration of women with disabilities in SRH programmes: There has been limited deliberate effort to increase access to MR, PAC and FP services among women with disabilities. For instance, RHSTEP and BAPSA partnered with CDD to train staff on SRHR and disability but this was a one-off training. Disability has not been well integrated into the training offered to service providers.<sup>88</sup>

Overall, women facing challenges in accessing MR, PAC and FP are those with low education, low financial capability, low awareness of SRH, women with disabilities and those residing in rural areas.

**Finding 2.7.2b: Although most of the targeted trainees attended training, a few trainees did not attend due to late invitation, COVID-19 pandemic and personal reasons.**

Most service providers targeted for training did participate in the training. A few trainees did not attend due to late notification about the training, COVID-19 pandemic, and individual reasons such as personal values and age. However, these barriers were not widespread given that a high percentage of targeted trainees attended the training and, in some years, the targeted number of trainees was surpassed.<sup>89</sup> The BAPSA and RHSTEP staff also attended training with no significant barriers.

**Findings 2.7.2c: Communities, garment factory workers, school students and youth targeted received SRHR information and services during the time the outreach activities were being implemented (years 1 and 2) after which the community programme was scaled down.**

The community, garment factory workers, school students and adolescents and youth accessed SRHR information and services in year 1 and 2 of the programme with no barrier. From year 3 onwards, the community programme was scaled down due to financial constraints.<sup>90</sup>

## 4.3 EFFICIENCY

**EQ EF1: Were RHSTEP and BAPSA capable of implementing the program?**

**Finding 3.1.1a: Well-functioning oversight bodies (executive committees and project advisory committee) ensured oversight of programme implemented and programmatic and financial accountability to the donor and other stakeholders.**

The executive committees (EC) of both organisations functioned as expected. The ECs approved policies, programme work plans and budgets; and reviewed programmatic

<sup>87</sup> Interviews with BAPSA and RHSTEP HQ and clinic staff, MoHFW officials and NGOs.

<sup>88</sup> Interviews with BAPSA and RHSTEP HQ and clinic staff, MoHFW officials and NGOs.

<sup>89</sup> Refer to data under finding 4.2.2a.

<sup>90</sup> Programme annual reports, interviews with RHSTEP and BAPSA staff and interviews with teachers and FGDs with CSG, adolescents and youth and women.

and financial reports and made decisions to improve programme implementation and ensure accountability to Sida and other stakeholders.<sup>91</sup>

The Project Advisory Board (PAB) also functioned as expected. The PAB reviewed and finalised work plans and budgets to ensure they are within the agreement with Sida and are harmonised with government plans; reviewed monitoring reports to address any emerging issues; reviewed programmatic and financial reports from RHSTEP and BAPSA to ensure they provide a clear account of programme implementation and financial expenditure; and compiled the final programmatic and financial reports submitted to Sida. These functions ensure effective management, implementation and accountability of the programme.<sup>92</sup>

**Finding 3.1.1b: Financial, procurement and supplies, and management information systems and internal and external audits contributed to effective management and implementation of the programme. However, internal controls are relatively weak, especially for BAPSA; both organisations lack an M&E expert and monitoring of the community programme could be improved.**

Both organisations have financial management systems in place used to manage the programme funds. RHSTEP has an electronic financial management system - Tally which is a web-based system linked to all its clinics and staff have been trained on the use of this system. This system produces the required financial reports. There are also guidelines in place for disbursement of funds from RHSTEP to BAPSA. External audits of the Safe MR Programme are carried out annually. Overall, the audits show that the financial systems in place are adequate although a few weaknesses were identified especially on tax management and internal controls.<sup>93</sup>

Internal audits are also carried out regularly to assess compliance with financial, procurement and supply and organisational management standards and guidelines. The audits found fewer weaknesses in the RHSTEP than in BAPSA. The issues identified are similar to those identified by the external auditor and point to non-compliance with some tax policies and weak internal controls. There have been attempts to address these issues but they also kept recurring from year to year especially with regard to BAPSA.<sup>94</sup>

A procurement and supply systems policies and guidelines are in place, an inventory and fixed assets software has been installed, the system for requisition by clinics and receipt of goods and services as well as storage is in place and is followed. Staff have been trained on the procurement and supply, and inventory and asset management guidelines.<sup>95</sup>

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<sup>91</sup> Key informant interviews with BAPSA and RHSTEP staff including EC members.

<sup>92</sup> Minutes of PAB meeting from 2018 to 2023 and interviews with RHSTEP and BAPSA staff.

<sup>93</sup> Interviews with RHSTEP and BAPSA staff and minutes of PAB meetings from 2018 to 2023.

<sup>94</sup> Internal audit reports from 2018 to 2023 and interviews with BAPSA and RHSTEP staff.

<sup>95</sup> Internal audit reports from 2018 to 2023 and external independent audit annual reports as well as interviews with BAPSA and RHSTEP staff.

The consortium has in place a monitoring and evaluation system comprising: a) A web-based Management Information System software connecting all clinics. This system tracks patient data in real-time enabling staff at head office to monitor activities in each clinic. Staff have also been trained on how to use this system. The MIS produces quantitative performance reports.<sup>96</sup> b) Supervision and monitoring visits to clinics carried out using a standardised checklist through which weaknesses are identified, a quality improvement plan developed and followed up to implementation.<sup>97</sup> Monitoring visits are also carried out to community activities and monitoring reports detailing the people reached and issues discussed. This monitoring has less focus on assessing SRHR knowledge gained through the community activities. d) Training is also supervised in partnership with the DGFP, pre and post training questionnaires are filled.<sup>98</sup> e) Client exit interviews are carried out every six months to assess patient satisfaction with services and identify areas that need improvement.<sup>99</sup> However, there is no M&E expert in both organisations and M&E tasks are distributed to several staff.<sup>100</sup>

**Finding 3.1.1c: RHSTEP and BAPSA have skilled programme management and clinical staff to implement the training and clinical components of the programme, but the number of staff is not adequate.**

Both BAPSA and RHSTEP have directors, programme, finance, procurement and logistics, information technology staff at the head office capable of managing the programme. In addition, RHSTEP has a research officer. Some of the staff are multitasking. For instance, directors and deputy directors in both organisations are responsible for overall management of the programme, developing plans, reports, managing staff; monitoring and supervising clinical services; training service providers, conducting advocacy and networking activities, supporting research and planning and implementing the community component of the programme. Due to budgetary limitations, both organisations lack (a) a community and advocacy expert to support the community programme; and (b) an M&E expert

Despite these constraints, the staff at the head office are highly committed to the vision of each organisation given the very low staff turnover and have developed extensive skills and experience over the years. Table 6 below show that 21% of RHSTEP staff have worked in the organisation for over 30 years while 25% and 28% have worked in RHSTEP and BAPSA respectively. Overall, the table shows a high stability or retention of staff in the head office of the two organisations.

**Table 6: Staff retention - Number of staff who have worked in each cluster of years in RHSTEP and BAPSA**

<sup>96</sup> Quantitative Performance Reports produced from the MIS system and interviews with BAPSA and RHSTEP staff.

<sup>97</sup> Monitoring checklist capacity building and service delivery tool.

<sup>98</sup> Training reports such as training report for mainstreaming gender equality and human rights approach, ToT for GBV and FWV training.

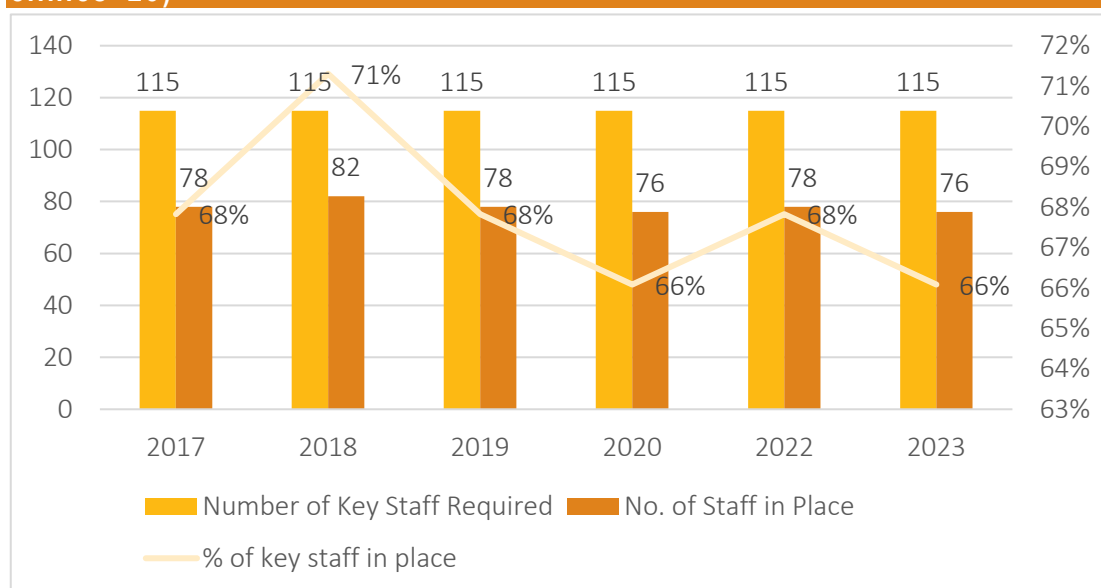
<sup>99</sup> Reports of the exit interview surveys done every six months from 2018 to 2022.

<sup>100</sup> Key informant interviews and organisational structure for BAPSA and RHSTEP.

Years worked	BAPSA		RHSTEP	
	Number of staff	Percentage of total	Number of staff	Percentage of total
35>	-		6	21%
25-34	5	28%	7	25%
15-24	4	22%	11	39%
0-14	9	50%	4	14%

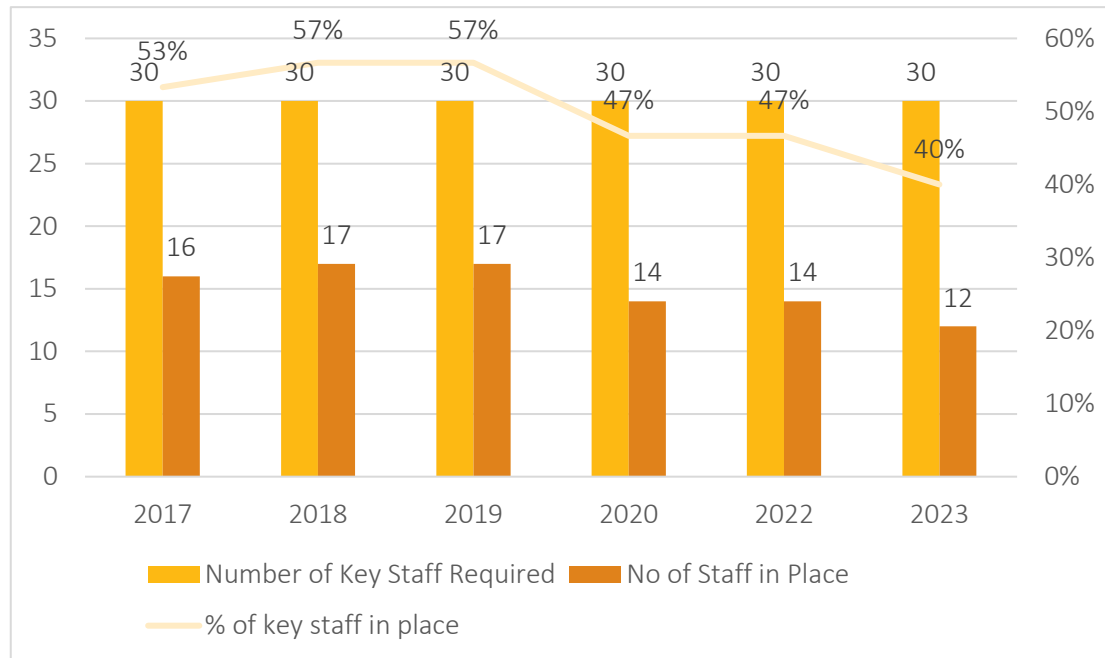
At clinic level, the number of core staff needed to provide the basic clinical services were assessed.<sup>101</sup> The assessment covered 23 RHSTEP clinics and 6 BAPSA clinics and focused on the availability of staff for 5 core positions - medical officer, nurse, counsellor, paramedic and laboratory technician. These are positions that each clinic should have irrespective of size. Figure 24 and 25 shows the results of this analysis.

**Figure 24: RHSTEP - Number of core staff that should be in place in each clinic against the number of core staff in place (No. of assessed clinics=23)**



<sup>101</sup> This assessment was based on the human resources data provided by RHSTEP and BAPSA.

**Figure 25: BAPSA - Number of key staff that should be in place in each clinic against the number of key staff in place (No. of clinics assessment = 6)**



The core staff in place in 23 RHSTEP clinics ranged from 66% to 68% annually (from 2017 to 2022). In BAPSA staff, the core staff in place ranged from 40% to 57% annually. This means that some clinics did not have all the key staff in place from year to year and the clinics fill in these gaps through multi-tasking.<sup>102</sup> In addition, this analysis also points to staff turnover, albeit low, from year to year partly due to budgetary limitations.<sup>103</sup> Patient flow varies from clinic to clinic and therefore, in clinics with low patient flow, multi-tasking improves efficiency while in clinics with a high patient flow, multitasking leads to heavy workload. Despite the staffing challenges, exit interviews show a high level of patient satisfaction with the services provided.

The FWVs or counsellors are expected to undertake outreach interventions to schools, garment factories workers and the community, with support from the medical officer and/or programme staff from head office. However, there is on average one counsellor and one FWVs in most clinics who are fully engaged in supporting clinical services to be able to conduct community activities.

**Finding 3.1.1d: RHSTEP and BAPSA applied programme management and implementation approaches that optimised the use of existing human and physical resources but changes in prices, during the programme period increased the actual unit costs compared to budget unit costs for most services.**

<sup>102</sup> Interviews with BAPSA and RHSTEP staff in the clinics.

<sup>103</sup> Interviews with BAPSA and RHSTEP staff.



Both organisations adopted approaches that improved cost efficiency. For instance, RHSTEP clinics are located in government hospitals where they don't incur rental cost; staff for both organisations multi-task; in-house experts are used to conduct trainings complemented by external experts; RHSTEP also conducts research using staff complemented by external experts when necessary to reduce cost. Further, due to the long-standing partnership with government, the two organisations are receiving family planning commodities from the government which has enabled them to provide FP services.

The unit cost analysis in the Annex 8 shows that most services and activities were delivered at a higher unit cost than was budgeted. The variances are higher in BAPSA than RHSTEP. This was attributed to changes in market prices and more specifically the high inflation that hit the country after the COVID-19 period. However, it also points to the differences in implementation processes between RHSTEP and BAPSA given the high differences in unit costs for the same activity between these organisations.

***EQ EF2: How flexible was the programme in adapting to changing needs when it comes to human, environmental, financial and time resources?***

**Finding 3.2.1a: The programme was well adapted to respond to COVID-19 pandemic which was the major unforeseen change during the programme implementation period.**

The major unforeseen change that disrupted programme implementation was COVID-19. The pandemic disrupted activity implementation for about 66 cumulative days. Programme field activities were suspended, staff worked from home and while others took the risk to open clinics. Clients' flow reduced; training of RHSTEP and BAPSA staff was organised virtually while community activities could not take place. The consortium estimates that about 30% of the activities could not be implemented. To respond to this disruption, the consortium revised activity plans to accelerate implementation, but the plans were disrupted by new waves of the pandemic. The loss of time to a large extent necessitated the extension of the programme period from December 2021 to June 2023 with activities ending in December 2022.<sup>104</sup>

**Adaptation of human resources:** The consortium had staff working from home and virtually during the COVID-19 pandemic. Staff in the clinics were provided with required protection to continue providing services. Mobile services offered through telephone also increased as these mitigated COVID-19 infection.<sup>105</sup>

**Adaptation of financial resources:** The Consortium used funds from the contingency budget line (with Sida approval) to purchase personal protective equipment (PPEs) for

<sup>104</sup> Project proposal for Strengthening of Safe MR and Family Planning services and Reduction of Unsafe Abortions for improving SRHR situation in Bangladesh (Safe MR Project) - Phase II January to December 2022.

<sup>105</sup> BAPSA and RHSTEP staff interviews and the Revised quantitative activity and revised budget for 2021.



staff and patients, and infection prevention commodities such as sanitisers and handwashing installations.

Adaption of environmental resources: Environmental resources were not impacted by any change. Both organisations have in place a service agreement with PRISM Bangladesh for waste collection. Both organisations also follow public/MoHFW waste management guidelines.<sup>106</sup>

***EQ EF3: What are the challenges, gaps and opportunities experienced during the implementation of the programme?***

**Finding 3.3.1a: During the programme implementation period, gaps related to MR integration in government services, MR policy, capacity of laboratories, and social stigma emerged but these gaps could not be addressed due to funding limitations.**

Gaps that emerged during implementation at the community level and service level, according to key informants, include: a) MR is not very elaborate in the government policy and the MR programme is not integrated on a large scale within government. b) Government policy needs to be revised to facilitate MR accessibility. c) MR clients in health facilities including the RHSTEP and BAPSA clinics are reducing due to MRM availability in pharmacies and drug stores. This is a gap in the provision of quality and safe MR services.

**Finding 3.3.1b: The programme faced challenges related to funding and political unrest which hinders effective implementation.**

Challenges emerging during the programme implementation period included:<sup>107</sup> a) Reduced funding especially in 2021 which affected especially the community programme. b) Dependency on one donor for the MR programme is a key challenge for the consortium. In addition, donors are reducing funding to the South East Asia region including Bangladesh. c) Political unrest in Bangladesh hindered clients from accessing clinical services and community programme activities as people could not travel due to fear and life-threatening consequences.

**Finding:3.3.1c A few opportunities emerged during the implementation period related training of service providers on MR, and establishment of linkages with pharmacies.**

Older carders of FWVs and paramedics are retiring and new ones are being recruited. Midwives have also been included in the staff category to be trained on MR. Further MR is included in the MoH operational plan, thus presenting an opportunity for provision of continuous training. Secondly, although accessing of MR through pharmacies is seen as a gap in the programme, it also presents an opportunity for the consortium to sensitise and create links with pharmacies to improve self-administered MR services.

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<sup>106</sup> Key informant interviews with BAPSA and RHSTEP staff at HQ and clinics.

<sup>107</sup> BAPSA and RHSTEP staff and annual reports.

## 4.4 SUSTAINABILITY

***EQ S1: Are the organisations - RHSTEP and BAPSA - capable of identifying the key best practices and lessons learnt from the programme and has it been documented, analysed, and integrated into the program, and can be scaled up in future?***

**Finding 4.4.1a: RHSTEP has not developed adequate capability to identify best practices and lessons. In addition, best practices and lessons from the safe MR programme were not documented.**

RHSTEP recruited a research officer and provided a budget for research activities. However, these funds were mainly utilised client exit interviews and 3 researches. Programme best practices and lessons were not assessed and/or documented.

***EQ S2: Is there a financial/ economic phase-out strategy? If so, how likely is it to be implemented beyond the programme life?***

**Finding 4.4.1b: RHSTEP and BAPSA do not have a financial phase-out strategy, but the organisations are pursuing financial sustainability through implementation of their organisational strategic plans. The likelihood of these strategies being implemented beyond the programme period is assessed as moderate given that the strategies will require funding beyond the income the consortium is generating. Some of these strategies include a key innovation in digitising the systems or both organisations to reduce cost.**

RHSTEP and BAPSA have no detailed financial phase strategy in place but they have strategic plans 2021 to 2025 which serve as their roadmap to sustainability. Both organisations are pursuing the following strategies towards financial sustainability:

a) Establishment of a training centre to generate income. RHSTEP is currently searching for land to build a full-fledged training centre. Given the financial outlay that such an investment will require, this is a long-term plan and the return on investment will depend on continued training of government, NGOs and private service providers. Success will depend on whether this demand will be sustainable. BAPSA is not pursuing this strategy.

b) Phasing out clinics from Sida support. Clinics which attain an income level that can support their operations are phased out of Sida support. The clinics phased out during the programme period as shown in the table below. This phase out approach encourages clinics to strive to attract more patients and increase their income. During this programme period, RHSTEP phases out 13 out of 28 clinics while BAPSA phased out 2 out of 9 clinics.

c) Digitisation of RHSTEP and BAPSA: Digitisation is a key innovation that is being introduced in both organisations to increase cost efficiency in service delivery and in running the organisation. This process has partly started with the establishment of web-based MIS, electronic financial systems and electronic inventory management system.

BAPSA has only recently commenced this process and some of its systems such as the inventory software are not yet fully installed.<sup>108</sup>

d) Establishment of a marketing unit: Both organisations are planning to establish a marketing unit to brand and increase visibility of programmes and services. This will strengthen the value proposition of the organisations to support resource mobilisation. However, the two organisations have been mobilising financial resources to a certain degree of success. Annex 9 shows that BAPSA mobilised about 1 billion Taka while RHSTEP mobilised 98 million Taka.<sup>109</sup>

e) Charging for services: This is another approach towards financial sustainability. The data below shows income generated during the programme period. However, RHSTEP and BAPSA face the challenge of setting charges at the level of full cost recovery, as is the case with other NGOs and private sector, while implementing a pro-poor strategy. Thus, there is a limit to the income the two organisations can generate.

**Table 7: Projected income vs Actual income for RHSTEP and BAPSA**

<b>RHSTEP</b>					
	<b>2017-2018</b>	<b>2018-2019</b>	<b>2019-2020</b>	<b>2020-2021</b>	<b>Total</b>
Project Net Income	40,632,629	39,436,213	36,229,538	34,317,735	150,616,115
Actual Net Income	39,204,727	49,812,693	34,315,480	38,395,815	161,728,715
% of project net income achieved	96%	126%	95%	112%	107%
<b>BAPSA</b>					
	<b>2017-2018</b>	<b>2018-2019</b>	<b>2019-2020</b>	<b>2020-2021</b>	<b>Total</b>
Project Net Income	19,125,000	20,165,000	21,280,000	24,430,000	85,000,000
Actual Net Income	15,310,905	16,170,756	13,776,715	15,487,069	60,745,445
% of project net income achieved	80%	80%	65%	63%	71%

f) Continued government support: Government has been providing FP commodities free of charge and the two organisations have also been training government service providers which generates some income. There is a likelihood of this relationship being sustained in the future. On the other hand, donor support to the organisations is limited. Sida has been the only major donor for the MR programme. Donor support, especially for MR and PAC programme is not likely to expand.

<sup>108</sup> Interviews with RHSTEP and BAPSA staff.

<sup>109</sup> This includes SIDA funding since 1990 which make to total among.

## 4.5 CROSS-CUTTING THEMES: GENDER AND HUMAN-RIGHTS APPROACH

***EQ C1: What are the main challenges in integrating gender equality and human rights-based approaches?***

**Finding 5.1.1a:** The consortium is at the nascent stage of establishing foundational tools and capacity of staff to integrate gender equality and human rights-based approaches (HRBA) in the programme. Gender equality and HRBA have not been fully operationalised in the programme because it takes time to change mindset and attitudes, develop skills, and establish implementation approaches, relevant partnerships and a monitoring system.

During the period of this programme, RHSTEP updated its gender policy and developed the “Protecting and Preventing Sexual Harassment and Inappropriate Behaviour (SHIB) Policy”, the guidelines for human rights-based approach to programming, and the gender mainstreaming strategy and draft manual. RHSTEP and BAPSA staff were trained on gender transformative approaches, SHIB and SGBV psychosocial counselling while gender was also included in MR training curriculum. Government, NGOs and private sector service providers were also trained on gender equality issues. At the clinics, the consent form has been modified to remove the need for consent of the husband to receive MR, PAC and other SRH services.

Despite the progress made, the integration of gender equality and human rights in the programme faced various challenges. Most staff have worked in RHSTEP and BAPSA for about 20 years and it takes time to change their mindsets and attitude. Secondly, it will take more than one training to change the attitude and behaviour of staff. Similarly, one training was conducted on SRHR and disability and this is not adequate to integrate disability into the programme. The MIS in place does collect data disaggregated by sex and the gender indicators included in the programme document were not monitored and reported. In addition, data was not disaggregated by disability and LGBTQI.

The inclusion of gender equality and human rights into the community interventions has not been explicit. Focus has been on sensitising garment factory workers, school students and teachers and communities on SRHR but underlying gender issues such as child marriage, the rights of women to make decisions on SRH issues are not emphasised.<sup>110</sup>

***EQ C2: How is the knowledge and participation of women and other stakeholders, ensured and their voices heard and respected (so that they can choose MR/PAC/contraceptives etc) and what were the main challenges?***

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<sup>110</sup> Interviews with RHSTEP and BAPSA staff at head office and clinics, interviews with government officials and NGOs, FGDs with women, adolescent girls, school teachers, community support groups and women groups and documents review.

**Finding 5.2.1a: The programme provided SRHR information to women and girls through community activities especially in the first two years of but platforms for empowering women to express their concerns and be heard were not established.**

The focus of the programme was on providing information on SRHR and less on establishing networks to advocate for and empower women and girls. The programme provided information on SRHR through the community outreach component<sup>111</sup> and the Alodhara Patshala.<sup>112</sup> However, a platform where women could express their concerns and be heard has not been established. Challenges limiting women's empowerment included the limited capacity within the consortium itself to integrate gender equality and women's empowerment in the programme; and lack of partnerships with women rights organisations with expertise, experience and local networks to empower women and girls.<sup>113</sup>

The targets and results of WRA receiving the MR/MRM services declined over the programme period. Targets declined by 58% between 2017 and 2022 while the results declined by 55% in the same period. The decline is largely due to an increase in the number of women accessing MRM through pharmacies and drug stores.

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<sup>111</sup> Programme annual reports and programme data and interview with BAPSA and RHSTEP staff.

<sup>112</sup> FGDs with Aldhara Pathshala members, and RHSTEP and BAPSA staff.

<sup>113</sup> Interviews with RHSTEP and BAPSA staff, NGOs and women, girls and Community Support Groups.

## 5 Conclusions

This section presents the conclusions arising from the evaluation findings. The conclusions are organised according to the evaluation criteria:

### **Relevance**

#### Conclusion 1

Safe MR Programmes was well aligned with the Swedish SRHR Strategy for Bangladesh and its ToC. The programme was also relevant to and addressed the health and SRHR needs of women and girls. However, the programme did not clearly define SRH needs of women with disabilities and LGBTQI people.

### **Effectiveness**

#### Conclusion 2

Training on MR, PAC, FP (among other SRHR areas) is a key comparative advantage of RHSTEP and BAPSA which is well recognised by government and other NGOs. As a result, the MoHFW/DGFP has retained both organisations as key training service provider in its annual training plans. However, there is a need for improving the collaboration with MoHFW to ensure timely invitations and to address any concerns service providers may have on the trainings to ensure all participants attend training.

#### Conclusion 3

A significant proportion of the targeted groups accessed SRH services in the RHSTEP and BAPSA clinics. However, WRA including adolescent girls continue to face socio-cultural and religious barriers compounded with low awareness of SRHR. Furthermore, there was no specific approach for reaching out to women with disabilities and LGBTQI people.

#### Conclusion 4

Services provided by RHSTEP and BAPSA clinics vary according to location, patient flow and capacity of the clinics. Services are also offered depending on the type of staff in place as shown in the clinic staffing analysis.

#### Conclusion 6

Knowledge and awareness on SRHR is still a huge need in the community, among adolescents and youth and for garment factory workers. However, community interventions were implemented at small scale and less intensity due to limited funding

### **Efficiency**

#### **Conclusion 7**

RHSTEP and BAPSA have the governance, financial, procurement and supply chain, programme management and training as well as internal audit capability to implement the safe MR programme, but weaknesses were identified in internal controls. The organisations also have the skilled staff needed to manage and implement programmes and the number of staff is inadequate.

#### **Conclusion 8**

Although RHSTEP has established some capability for undertaking research, this capability is not adequate and the research so far undertaken has been underutilised. BAPSA, on the other hand, is yet to establish research capability.

### **Sustainability**

#### **Conclusion 9**

Sustainability remains a major concern. RHSTEP and BAPSA have not developed a financial sustainability plan and the sustainability strategies being pursued will require additional funding, take time to implement and realise results.

### **Gender and human rights integration**

#### **Conclusion 10**

Integration of gender equality and human-rights based approaches in the MR programme is at the initial stages, having developed policies and guidelines for mainstreaming. However, it will take time to change mindsets and build adequate capacity for gender and human-rights based approaches mainstreaming.

## 6 Recommendations

Recommendation	Responsibility (Lead entity)	Other contributing entities	Ranking
<b>Recommendation 1:</b> In the next Safe MR Programme, RHSTEP and BAPSA should consider including: 1) component on pharmacies linkage or partnership; 2) a scale up of mobile services; 3) establishing community to clinic referral; 4) prioritising clinics based in rural areas to enable the programme strengthen linkages to a revamped community component.	PAB		1
<b>Recommendation 2:</b> In the next Safe MR Programme, the community component should be scaled up through innovative approaches. RHSTEP and BAPSA should hire technical assistance to assist in remodelling the community component to address the barriers to accessing MR, PAC, FP, Cancer screening and Safe Motherhood services. Special attention should also be provided to women with disabilities and LGBTQI.	PAB	Sida and DGFP	2
<b>Recommendation 3:</b> RHSTEP and BAPSA should develop an action plan with clear goals, indicators and timeline for integration of gender equality and human rights (including establishing platforms for women's voice, integrating women with disabilities and LGBTQI people). The programme should also include sensitisation of people with disability and LGBTQI. Indicators tracking this integration should be part of the programme results framework.	PAB	DGFP, Like minded NGOs	3
<b>Recommendation 4:</b> In the next Safe MR Programme: a) SRHR (particularly MR, PAC, FP) advocacy needs should be well defined, have a clear ToC and appropriate implementation modalities. The consortium can consider seeking technical assistance to design the advocacy component of the programme, so that the objectives of advocacy and networking events are clearer. b) Ensure coherence of the programme through strengthening linkages between community sensitisation, demand creation for MR and other SRH services, advocacy, and community to clinics linkage	Sida	RHSTEP and BAPSA	4



<b>Recommendation 5:</b> In the next Safe MR Programme, RHSTEP and BAPSA should consider recruiting: 1) an M&E expert and 2) A community outreach and advocacy officer to strengthen these aspects of the programme	ED RHSTEP and ED, BAPSA		5
<b>Recommendation 6:</b> RHSTEP and BAPSA should consider developing a costed research agenda based on a well-defined research priority. The strategy should include documentation of best practices and lessons; and approaches for utilisation of research recommendations	PAB		6
<b>Recommendation 7:</b> RHSTEP and BAPSA should consider developing a long-term clinic specific growth plan which will include expected income growth	ED RHSTEP and ED, BAPSA		7
<b>Recommendation 8:</b> The consortium should consider undertaking organisational development for BAPSA with emphasis on strengthening financial and procurement and supply management and internal controls.	ED, BAPSA	RHSTEP and Sida	8
<b>Recommendations 9:</b> To enhance sustainability, consider: (a) Developing a financial sustainability plan with targets, work plan and cost (b) Scale up digitisation of the two organisations to improve efficiency	ED RHSTEP and ED, BAPSA		9
<b>Recommendation 10:</b> RHSTEP and BAPSA should develop an investment case for establishing a training centre for SRHR. Such a plan will enable RHSTEP to determine whether to continue pursuing this project.	ED, RHSTEP and ED, BAPSA	Sida and DGFP	10

# Annex 1 – Terms of Reference



## **Evaluation of Strengthening of Safe MR and Family Planning services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe Menstrual Regulation (MR) program)**

Date: 23.03.2023. Case number: 52170024

### **1. General Information**

#### **1.1.Introduction**

Many men, women and youth in Bangladesh are still denied basic rights by their governments and by tradition. Despite several statements on health and SRHR ratified by the country, there is still systemic discrimination based on gender, as well as incidents of the enforcement of self-interpreted view of religious law in some communities. A growing wave of conservative, religious led opposition to SRHR and gender equality is seeking to turn back the clock.

In 1979 the government of Bangladesh introduced an innovative and pragmatic solution namely “Menstrual Regulation” (MR) into its national family planning program, an effort to reduce the number of unsafe abortions. However, studies have found numerous barriers to obtaining access to MR. More than half of ever married women do not know about the MR program, and about one quarter of women who seek MR are turned down by providers, often for reasons not sanctioned by government guidelines. Studies have also documented cost as a barrier to care. Although MR services are supposed to be offered to women free of charge, reports of unauthorised charging for services are common.

#### **1.1 Evaluation object: intervention to be evaluated**

Embassy of Sweden has been supporting the Sexual, Reproductive Health and Rights (SRHR) related interventions particularly Menstrual Regulation Programme and post abortion care in Bangladesh since 1993. Reproductive Health Services, Training and Education Programme (RHSTEP) and Bangladesh Association for Prevention of Septic Abortion (BAPSA), are two national NGOs which have been receiving long term Sida

support since 2004. In accordance with the agreement between the Embassy and RHSTEP, the Embassy disburses fund to BAPSA through RHSTEP.

The overall goal of the program is to contribute in improving SRHR and wellbeing of women, men and adolescents in Bangladesh. The purpose of the program is to reduce maternal mortality, morbidity from unsafe abortion and improve the SRHR situation of women and adolescents in the project areas. The goal and purpose will be achieved by improving skills of service providers of SRHR, increasing access to quality SRH services for women, adolescents and men, enhancing knowledge of the women and adolescents in the project areas to make informed choice pertaining to their sexual and reproductive health needs. Moreover, this project aims to ensure that women who undergo abortion are not further stigmatised or harmed by the process.

In October 2017 the Embassy signed an agreement with RHSTEP for four years (2017-2021). Sida support amounts to 61.5 MSEK. The budget is allocated for service (78%), community outreach program (5%), monitoring, evaluation and documentation (4%), capacity building (9%) and policy advocacy (2%). The program was extended in December 2021 for another 15 months. The agreement will end in June 2023 and the activity period is ended in December 2022 and RHSTEP requested for costed extension.

## **1.2.The rationale of the evaluation**

The evaluation will be carried out at the point in time as Sida's support to RHSTEP is ending and Sida plans to assess continued support to RHSTEP program. Sida has funded the program for 30 years and conducted several evaluations and assessments. It is important for Sida to understand the added value, comparative advantage and the cost effectiveness of the program and, most importantly, how RHSTEP can influence SRH services beyond RHSTEP specific program.

The evaluation will be an important input in to the appraisal for the planned and last support to RHSTEP. It will also be an important input in the dialogue with RHSTEP both on the program in itself but also on issues in the area of SRHR in Bangladesh. It is Embassy's intention that the conclusions and recommendations from the evaluation will be useful for future cooperation. The Embassy wants to learn how relevant the program is in relation to the strategy objectives and the ToC for the support area.

The evaluation should take into consideration previous evaluations commissioned by Sida or others.

The Embassy of Sweden is planning to use the Sida framework agreements for evaluation services to undertake the evaluation of the project, namely the Sexual and Reproductive Health and Rights (2017-2023)

### **2.1.Evaluation overall purpose: intended use and intended users**

**The purpose of the evaluation** is to assess the SRHR project and how it is contributing to the Strategy for Sweden's Development Cooperation objective related to SRHR "Better opportunities for access to, and respect for, sexual and reproductive health and rights".

It will:

- Help Sida to assess progress of the intervention as input to upcoming discussions of a new phase of the intervention,
- Serve as an input for Sida in the overall dialogue and advocacy of SRHR in Bangladesh.

The primary intended user of the evaluation is the Swedish Embassy and RHSTEP, Bangladesh

### **2.2.The evaluation objective**

The objective of this evaluation is to provide the Embassy with information on the: relevance; effectiveness; efficiency; sustainability; and to what extent the program's achievement and how it contributed to the objective of the Swedish Strategy.

More specifically the consultant/s will:

- Assess the program strategies, implementation and accomplishments as well as challenges and how they have been solved during the implementation period 2017-2022.
- Measure the achievements of the program against the set outcomes and related indicators.
- Assess funds budgeted and spent, the division of funds on different types of costs and estimates on cost-efficiency.
- Review the long-term sustainability strategy of RHSTEP and BAPSA.
- Assess the collaboration between the government and RHSTEP and BAPSA and to what extent the program is integrated to the health system.

### **2.3.The questions to be asked**

#### **Relevance: Is the intervention doing the right thing?**

Is the program relevant to the Swedish strategy for Bangladesh and the theory of change of the strategy and the health and SRHR needs of the target group?

#### **Effectiveness: is the intervention achieving its objectives?**

1. Have all the intended target groups including women with disabilities, had access to the services and other deliverables provided through the program?

2. Are there any factors which prevent target groups accessing the MR, PAC training and other SRH services?

**Efficiency: has intervention delivered results in an economic and timely way?**

1. Were RHSTEP and BAPSA capable of implementing the program?
2. How flexible were the program in adapting to changing needs when it comes to human, environmental, financial and time resources?
3. What are the challenges, gaps and opportunities experienced during the implementation of the program?

**Sustainability: has the intervention factored in sustainability**

1. Is the organisations - RHSTEP and BAPSA - capable of identifying the key best practices and lessons learnt from the program and has it been documented, analysed, and integrated into the program, and can be scaled up in future?
2. Is there a financial/ economic phase-out strategy? If so, how likely is it to be implemented beyond the program life?

**Other questions:** *Specific questions to ask on gender equality and HRBA*

1. What are the main challenges in integrating gender equality and human rights-based approach?
2. How is the knowledge and participation of women and other stakeholders, ensured and their voices heard and respected (so that they can choose MR/PAC/ contraceptives etc) and what where the main challenges?

**3. Evaluation scope**

Some of the work will be conducted as a desk study, but the study should, if possible, include field visits to selected RHSTEP-BAPSA sites in Bangladesh and interviews with staff, stakeholders (to be guided by steering committee) and consenting clients. Field visits would be planned in close coordination with RHSTEP-BAPSA.

The geographical areas selected would be those receiving Swedish support and others as well if deemed relevant for the evaluation questions. If needed, the scope of the evaluation may be further elaborated by the evaluator in the inception report.

**4. Approach and Method**

The evaluator will produce a methodological framework to evaluate the intervention and share it with the Embassy and RHSTEP before commencing the evaluation.

Sida's approach to evaluation is utilisation focused. In utilisation focused evaluation, emphasis is put on identifying who the intended users of a specific evaluation are, and being specific about their intended use of the evaluation. To increase the utility,

evaluations commissioned by Sida shall be carried out in a spirit of partnership. Gender segregated data and gender analysis is also expected from the evaluation.

## **5. Stakeholder Involvement**

The evaluator shall visit the programme sites and meet the beneficiaries in their various categories and other stakeholders. Stakeholders who will be involved will include:

1. The service users, particularly the poor and vulnerable woman, girls and adolescents.
2. Community Leaders and gatekeepers.
3. Trainees and trainers.
4. Service providers.
5. Service recipients.
6. International and national civil society organizations providing MR, PAC services and their share of the MR, PAC service provision.
7. Ministry of Health and Family Welfare.
8. Multilateral and Bilateral development partners working on Menstrual Regulation (MR), Post Abortion Care (PAC) and other sexual and reproductive health and rights.
9. Health and Hospital Authorities – DGFP, DGHS, DGNM, Medical College Hospital Authority.
10. Any other Government agencies and stakeholders including religious leaders as may be discussed with RHSTEP and BAPSA.

## **6. Organisation of evaluation management**

This evaluation is commissioned by the Swedish mission in Bangladesh. Sweden will form a working group including the partner to review and approve the inception report and the final report of the evaluation. The working group will participate in the start-up meeting of the evaluation, as well as in the debriefing/validation workshop where preliminary findings and conclusions are discussed.

## **7. Evaluation quality**

All Sida's evaluations shall conform to OECD/DAC's Quality Standards for Development Evaluation. The evaluators shall use the Sida OECD/DAC Glossary of Key Terms in Evaluation and the OECD/DAC Better Criteria for Better Evaluation. The evaluators shall specify how quality assurance will be handled by them during the evaluation process.

## **8. Time Schedule, Reporting and Communication**

The consultant/s shall prepare and submit a preliminary work-plan and budget for the evaluation. He /She shall accomplish the work within an agreed timeframe of not more than 40-person days. This will involve travels to various areas, to consult and interview

various people, conduct desk reviews, analysis, preparation of a draft report, discussions with stakeholders for feedback on draft and preparation of the final report.

A brief inception report shall be submitted to RHSTEP and Embassy of Sweden before commencing the field work. Immediately after completing field work, a debriefing meeting will be held between RHSTEP, the evaluator, Embassy of Sweden (working group) and any other relevant stakeholders to validate the key findings. BAPSA

The Consultant(s) will submit draft reports to Embassy of Sweden for review and feedback five weeks after commencing the evaluation. The Consultant(s) will submit a consolidated final evaluation report one after receiving feedback and inputs from the Embassy, RHSTEP and BAPSA

The Final Evaluation report shall be submitted for approval by the Embassy of Sweden, not later than 1st July 2023.

The table below lists key deliverables for the evaluation process. Alternative deadlines for deliverables may be suggested by the consultant and negotiated during the inception phase.

<b>Deliverables</b>	<b>Participants</b>	<b>Deadlines</b>
1. Start-up meeting/s Stockholm and virtual	Sida staff, RHSTEP consultant	1st April 2023
2. Draft inception report	Consultant	22 April 2023
3. Comments on the first draft from intended users to evaluators	Sida/working group, RHSTEP	27 <sup>th</sup> April 2023
4. Inception meeting virtual meeting	Consultant, RHSTEP, Sida/working group	30 <sup>th</sup> April 2023
5. Key Informant Interview, FGD, client exit interview analysis, report writing and quality assurance	Consultant	1 <sup>st</sup> may to 15 <sup>th</sup> June 2023
6. Debriefing/validation workshop (meeting)	Consultants, RHSTEP, Sida	1 <sup>th</sup> June 2023
7. Draft evaluation report	Consultant	24 <sup>th</sup> June 2023
8. Comments from intended users to evaluators	RHSTEP, Sida/working group	28 <sup>th</sup> June 2023
9. Final evaluation report	Consultant	1 <sup>st</sup> July 2023
10. Possible Seminar	RHSTEP	6 <sup>th</sup> July 2023

**The inception report** will form the basis for the continued evaluation process and shall be approved by Sida before the evaluation proceeds to implementation. The inception report should be written in English and cover evaluability issues and interpretations of evaluation questions, present the evaluation approach/methodology (including how a utilization-focused and gender responsive approach will be ensured), including an updated and consolidated theory of change for the project, a stakeholder mapping, methods for data collection and analysis as well as the full evaluation design. A clear distinction between the evaluation approach/methodology and methods for data collection shall be made. All limitations to the methodology and methods shall be made explicit and the consequences of these limitations discussed. A specific time and work plan, including number of hours/working days for each team member, for the remainder of the evaluation should be presented. The time plan shall allow space for reflection and learning between the intended users of the evaluation.

**The final report** shall be written in English and be professionally proof read. The final report should have clear structure and follow the report format in the Sida Decentralised Evaluation Report Template for decentralised evaluations (see Annex C). The executive summary should be maximum 3 pages. The evaluation approach/methodology and methods for data collection used shall be clearly described and explained in detail and a clear distinction between the two shall be made. All limitations to the methodology and methods shall be made explicit and the consequences of these limitations discussed. Findings shall flow logically from the data, showing a clear line of evidence to support the conclusions. Conclusions should be substantiated by findings and analysis. Evaluation findings, conclusions and recommendations should reflect a gender analysis/an analysis of identified and relevant cross-cutting issues. Recommendations and lessons learned should flow logically from conclusions. Recommendations should be specific, directed to relevant stakeholders and categorised as short-term, medium-term and long-term. The report should be no more than 35 pages excluding annexes (including Terms of Reference and Inception Report). The evaluator shall adhere to the Sida OECD/DAC Glossary of Key Terms in Evaluation.

The evaluator shall, upon approval of the final report, insert the report into the Sida Decentralised Evaluation Report for decentralised evaluations and submit it to Nordic Morning (in pdf-format) for publication and release in the Sida publication data base. The order is placed by sending the approved report to [sida@nordicmorning.com](mailto:sida@nordicmorning.com), always with a copy to the responsible Sida Programme Officer as well as Sida's Evaluation Unit ([evaluation@sida.se](mailto:evaluation@sida.se)). Write "Sida decentralised evaluations" in the email subject field. The following information must always be included in the order to Nordic Morning:

1. The name of the consulting company.
2. The full evaluation titles.
3. The invoice reference "ZZ980601".
4. Type of allocation "sakanslag".
5. Type of order "digital publicering/publikationsdatabas".



## Annex 2 – Evaluation Matrix

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
Relevance: Is the intervention doing the right thing?	Is the program relevant to the Swedish strategy for Bangladesh and the Theory of Change of the strategy and the health and SRHR needs of the target group?	<ul style="list-style-type: none"> <li>- Evidence of MR Programme outcomes and interventions being consistent with Swedish strategy for Bangladesh</li> <li>- Alignment of MR Programme Theory of Change (ToC) with aligned ToC of Swedish strategy for Bangladesh</li> <li>- Evidence of health and SRHR needs of targeted groups being reflected in MR programme design and interventions</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> <li>- FDG guideline</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- Swedish strategy for Bangladesh (focusing on health) and TOC</li> <li>- MR programme document, performance framework, work plans and reports</li> <li>- Documents and data reviewed during MR programme design</li> </ul> <p>Interviews: with Sida, programme governance/ management structures, programme staff, MHFW, health and hospital authorities, service providers, trainers, community leaders, CSOs, and development partners</p> <p>Focus group discussions (FGDs) with service users – adolescent girls, WRA and men</p>	Qualitative analysis of data from documents reviews, KIIs and FGDs and triangulation of these data sources to assess the extent to which the MR programme contributed to objectives/ priorities of Sida health and SRH strategy and TOC, and needs to targeted populations. The MR programme ToC link with Swedish SRHR strategy will also assessed.

## ANNEX 2 – EVALUATION MATRIX

Effectiveness: Is the intervention achieving its objectives?	Have all the intended target groups including women with disabilities, had access to the services and other deliverables provided through the program?	<ul style="list-style-type: none"> <li>- Number of persons accessing services against set targets disaggregated appropriately (age, sex, disability, project site etc)</li> <li>- Percentage of persons accessing services against set targets disaggregated appropriately (age, sex, disability, project site etc)</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents and data</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- MR programme results/ performance framework</li> <li>- Programme work plans, progress/annual reports</li> <li>- Monitoring data</li> </ul>	Descriptive analysis of quantitative MR programme data comparing set targets for MR/PAC/RTI&STI/LCC services vs results achieved.
	Are there any factors which prevented target groups from accessing the MR, PAC training and other SRH services?	<ul style="list-style-type: none"> <li>- Evidence of factors hindering target groups from accessing services</li> <li>- Evidence of factors facilitating target groups from accessing services</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> <li>- FDG guideline</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- Programme progress/annual reports</li> <li>- Programme monitoring/supervision reports</li> <li>- Documentation of best practices and lessons learnt</li> <li>- Relevant external literature on SRHR</li> </ul> <p>Interviews: KIIs with programme governance/ management structures and staff, MHFW, health and hospital authorities, service providers, trainers, community leaders, CSOs, and development partners</p> <p>Focus group discussions (FGDs) with service users – adolescent girls, WRA and men</p>	<ul style="list-style-type: none"> <li>- Qualitative data analysis of KII and FGD as well as secondary data on how MR programme may have made it possible for target populations to access services based on their interventions; and factors hindering access. Data from KIIs, FGDs, programme reports, surveys and other literature will be triangulated.</li> </ul>

Efficiency: Has intervention delivered results in an economic and timely manner	Were RHSTEP and BAPSA capable of implementing the program?	<ul style="list-style-type: none"> <li>- Appropriateness of programme governance structures</li> <li>- Extent to which governance bodies and management performance their functions as expected</li> <li>- Appropriateness of systems (planning and implementation, M&amp;E, financial)</li> <li>- Appropriateness and adequacy of human resources (skills, number, staff turnover)</li> <li>- Adequacy of financial resources and absorption rate</li> <li>- Extent of delivery of the programme in an economic way</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents and data</li> <li>- KII guide</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- ToRs and minutes of meetings governance bodies</li> <li>- Budget and expenditure reports</li> <li>- Staffing data and profiles</li> <li>- Documentation on systems in place</li> </ul> <p>Interviews with RHSTEP, BAPSA, MoHFW and other government agencies, health and hospital authorities, service providers, trainers and community leaders, religious leaders and other gate keepers, development partners and CSOs</p>	<ul style="list-style-type: none"> <li>- Analysis of financial data: Expenditure by cost categories, and direct and indirect cost to establish percentage of funds spent by output vs results achieved, percentage of indirect cost for delivery of the programme. This analysis will establish whether the programme was delivered in an economic way.</li> <li>- Descriptive analysis of quantitative of programme and financial data</li> <li>- Qualitative data analysis of data from KIIs and FGDs</li> <li>- Data triangulation from all sources of data from all categories of KIs, FGDs and secondary sources.</li> </ul>
	How flexible was the programme in adapting to changing needs when it comes to human, environmental, financial and time resources?	<ul style="list-style-type: none"> <li>- Evidence of changing needs during programme implementation period</li> <li>- Evidence changes/adaptability of human resources to changing needs</li> <li>- Evidence changes/adaptability of financial resources to changing needs</li> <li>- Evidence changes/adaptability of environmental resources to changing needs</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- Programme work plans and budgets, annual reports</li> <li>- Documentation on changes made to human resources, environmental, and financial resources</li> </ul> <p>Interviews with RHSTEP, BAPSA, MoHFW and other government agencies, health and hospital authorities, service providers and trainers</p>	<ul style="list-style-type: none"> <li>- Qualitative analysis of data from KIs and secondary data and triangulation from all sources</li> </ul>

	What are the challenges, gaps and opportunities experienced during the implementation of the programme?	<ul style="list-style-type: none"> <li>- Types of gaps that emerged during implementation period</li> <li>- Types of opportunities that emerged during implementation period</li> <li>- Types of challenges that emerged during implementation</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- Annual reports, minutes/reports of programme review meetings, field monitoring, supervision, meetings of governance bodies</li> <li>- Documentation of best practices and lessons</li> </ul> <p>Interviews with RHSTEP, BAPSA, MoHFW and other government agencies, health and hospital authorities, service providers and trainers</p>	<ul style="list-style-type: none"> <li>- Qualitative data analysis and triangulation of data from all sources to establish the challenges and opportunities experienced during implementation</li> </ul>
Sustainability: has the intervention factored in sustainability	Are the organisations - RHSTEP and BAPSA - capable of identifying the key best practices and lessons learnt from the programme and has it been documented, analysed, and integrated into the program, and can be scaled up in future?	<ul style="list-style-type: none"> <li>- Existence of technical and financial capacity to document best practices and lessons</li> <li>- Evidence of best practices and lessons documented</li> <li>- Evidence of analysis and use of documented best practices and lessons</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> </ul>	<p>Documents</p> <ul style="list-style-type: none"> <li>- Documents/reports of best practices and lessons</li> <li>- Programme M&amp;E plan or knowledge management plan</li> <li>- Budget and staff allocated to knowledge management</li> <li>- Documented adjustments to the programme</li> </ul> <p>Interviews with RHSTEP, BAPSA, MoHFW and other government agencies, health and hospital authorities, service providers and trainers</p>	<ul style="list-style-type: none"> <li>- Qualitative analysis and triangulation of data from all sources to establish how best practices and lessons (if documented) were integrated in the programme and scaled up nationally.</li> </ul>

	Is there a financial/economic phase-out strategy? If so, how likely is it to be implemented beyond the programme life?	<ul style="list-style-type: none"> <li>- Existence and appropriateness of financial phase out strategy</li> <li>- Appropriateness and likelihood of funding sources materialising</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review of documents</li> <li>- KII guide</li> </ul>	<p>Documents: The financial/economic phase-out strategy</p> <p>Interviews with RHSTEP (management) and BAPSA (management) and MoHFW</p>	<ul style="list-style-type: none"> <li>- Qualitative analysis and triangulation of data from all sources to established whether the financial sustainability strategy is being implemented or has likelihood of being implemented</li> </ul>
Cross-cutting issues: Gender and HRA approach	What are the main challenges in integrating gender equality and human rights-based approaches?	<ul style="list-style-type: none"> <li>- Types of challenges in integration of gender equality and human-rights based approaches</li> <li>- Possible solutions to the challenges</li> </ul>	<ul style="list-style-type: none"> <li>- Documents review</li> <li>- KII guide</li> <li>- FGD guidelines</li> </ul>	<p>Documents:</p> <ul style="list-style-type: none"> <li>- Progress/annual reports</li> <li>- Best practices and lessons learnt reports</li> <li>- Relevant external literature</li> </ul> <p>Interviews: KIIs with programme governance/management structures and staff, MHFW, health and hospital authorities, service providers, trainers, community leaders, CSOs, and development partners</p> <p>Focus group discussions (FGDs) with service users, trainees, and service recipients</p> <p>Focus group discussions (FGDs) with service users – adolescent girls, WRA and men</p>	<ul style="list-style-type: none"> <li>- Qualitative analysis and triangulation of data from all sources on gender and HBA mainstreaming. Analysis of gender and HBA will also be integrated into analysis of data in all evaluation questions above.</li> </ul>

	<p>How is the knowledge and participation of women and other stakeholders, ensured and their voices heard and respected (so that they can choose MR/PAC/ contraceptives etc) and what were the main challenges?</p>	<ul style="list-style-type: none"> <li>- Types and appropriateness of approaches and interventions for increasing SRHR knowledge among women and other stakeholders (community leaders, religious leaders etc)</li> <li>- Types and appropriateness of approaches and platforms for women participation on SRHR advocacy</li> <li>- Types of challenges women faced in participation on SRHR advocacy</li> </ul>	<ul style="list-style-type: none"> <li>- Documents review</li> <li>- KII guide</li> <li>- FGD guidelines</li> </ul>	<p>Documents:</p> <ul style="list-style-type: none"> <li>- Progress/annual reports</li> <li>- Best practices and lessons learnt reports</li> <li>- Relevant external literature</li> </ul> <p>Interviews: KIIs with programme governance/ management structures and staff, MHFW, health and hospital authorities, service providers, trainers, community leaders, CSOs, and development partners</p> <p>Focus group discussions (FGDs) with service users – adolescent girls, WRA and men</p>	<p>Qualitative analysis and triangulation of data from all sources</p>
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# Annex 3 – Methods Section from Inception Report

## **Methodological approach for the evaluation**

### **1. Overall approach**

The overall approach for this evaluation will be as follows:

The evaluation will rely on a theory-based approach to assess the envisaged pathway to change and explore what happened, why/why not and for whom during implementation. The ET will also analyse the assumptions and risks influencing achievement of programme results and objectives. However, the programme does not have a ToC. The ET has constructed a ToC based on the understanding of the programme design as shown in the figure below. The ToC will apply this ToC during the execution of the evaluation.

The ToC above shows a one-to-one logical link between outputs and outcomes. This TOC will be interrogated during the evaluation to assess any other interlinkages between outputs and outcomes and underlying assumptions. For instance, training of service providers (doctors, paramedics, FWVs, SAMCOS and training of the consortium staff in the various clinics could contribute to provision of quality SRHR services. Therefore, a link between output 1 and 3 to outcome 3 is plausible. The increase of knowledge and awareness on SRHR among communities and target populations including men (output 4) and the advocacy work (output 6) could plausibly contribute to access to SRHR services by removing barriers.

The ET will apply a mixed methods approach for data collection. The intention is to collect both qualitative and quantitative data to inform analysis, with qualitative data stemming from desk review of documents, interviews; and quantitative data to be mainly drawn from documents and programme data. Data will be triangulated across data sources to ensure robustness of evidence.

*Stakeholder involvement:* During data collection, the ET will use a participatory approach to ensure stakeholders are involved in the evaluation. A tentative mapping of stakeholders has been completed, identifying stakeholders directly involved in the programme at all levels (national, district, sub district, and community level), internal stakeholders within the RHSTEP and BAPSA, external stakeholders involved in the MR programme including MoH (FP and HS directorates) and indirect stakeholders working in SRHR space as well as service users/beneficiaries. The mapping is also structured in a way that allows stakeholders to be clustered by programme outcome, type of stakeholder (government, CSOs, development partner, donor, and target

groups), role in the programme (programme management and implementation, service providers and trainers, development and collaborating partners), target groups (adolescents, women, men, and trainees) and level of operation (national, sub-national, community). The mapping ensures the voice of beneficiaries including adolescents, women, men, community leaders and gate-keepers voice is heard while triangulating data from all sources. The intention is to establish a 360 perspective. These dimensions of stakeholder analysis ensure that programmatic areas and all the evaluation questions will be covered (see annex 3 for the tentative stakeholder mapping).

*Evaluation matrix:* The evaluation matrix is central to all stages of the evaluation – design, data collection, analysis and reporting. An evaluation matrix has been prepared laying out the entire plan for the programme evaluation. In the matrix the ET has identified the evaluation indicators, sources of data, and data collection and data analysis methods for each evaluation sub-question. The ET has used this matrix to develop the data collection plan.

*Gender mainstreaming:* The evaluation team has adopted a gender-sensitive methodology as follows: (i) gender has been considered as a key factor in the stakeholder mapping and selection of key informants and focus groups to ensure a balanced representation of women and men. (ii) An evaluation question on gender and human rights has been included as a cross-cutting issue to be investigated. (iii) Data collection tools will include questions to elicit information on gender and human rights across relevant evaluation criteria and in all programme objectives. (iv) Data will be disaggregated by sex and age to the extent possible and underlying gender issues influencing access of women and adolescent girls to SRH services will be analysed.

## 2. Methodology

This section presents the approach for selection of key informants and project sites where data will be collected. All programme interventions will be covered, therefore, no selection criteria on project sites have been applied for this purpose.

*Selection of key informants:* A purposive criterion has been applied to ensure key informants selected can provide information on:

- All evaluation sub-questions
- All programme interventions under all outputs
- Risks and assumptions influencing programme implementation and results
- Gender equality and human-rights integration
- Perceptions of programme at all levels (national, districts and sub-districts/community)

*Selection of Focus Group participants:* Purposive selection criteria used to ensure (a) types of service users, and (b) all types of community leaders will be represented

*Sampling of project sites:* Data will be collected at the sites supported by the programme. The following criteria have been used to select these project sites:



- Performance of a site in reaching targets. In this regard, two sites with good performance and two sites with poor performance have been selected.
- Concentration of programme activities to ensure sites selected are a good representation of programme implementation
- Convenience to ensure the ET can reach the site within reasonable time and complete data collection within set time frame
- Coverage of both RHSTEP and BAPSA project sites with two sites selected for each organisation

In applying these criteria, the ET selected two project sites each for RHSTEP and BAPSA. For RHSTEP, Sylhet, and Dhaka (Shewrapara) districts were selected while Dhaka (Mirpur-6) and Gazipur (Boardbazar) districts were selected for BAPSA.

### 3. Methods and tools for data collection

The evaluation will apply qualitative data collection methods while also using existing secondary quantitative data as well as financial data. The data collection methods are as follows:

*Desk review of documents and data:* Documents relevant to each evaluation sub-question will be reviewed. The type of documents to be reviewed are identified in the evaluation matrix and they include: (i) programme documents such as the proposal, results framework, work plans, annual reports, previous evaluation reports, monitoring data, and financial data (budgets and expenditure reports). (ii) knowledge, best practices, lessons learnt and other products produced by the programme; (iii) policy and strategy documents on SRHR that provide contextual information among others. Preliminary review of documents has been done in the inception phase while an in-depth review will be carried out during the data collection phase.

*Semi-structured interviews with key informants:* KIIs will be conducted using an interview guide tailored to the role of the stakeholder in the programme. Interviews will be conducted in face-to-face meetings, although stakeholders who request virtual interviews will be accommodated. KIs have been selected from the broader stakeholder mapping and comprise:

- MR programme governance bodies, management, technical and support staff of RHSTEP and BAPSA. Separate meetings will be held with each group; and these meetings can be held as individual or group meetings.
- External stakeholders working directly with RHSTEP and BAPSA in programme implementation including the MoHFW and other government authorities, hospital authorities, medical colleges, service providers, trainers and CSOs
- Development partners including Sida

*Focus group discussions (FGD)* up to 8-10 participants, using an FGD guide tailored to the type of group. FGDs participants will include service users covering (a) adolescent girls, (b) women, and (c) men, (d) adolescent girls and boys (Alodhara

Patshala) FGDs are expected to last for 1 ½ hours and 2 hours. 2 FGDs per district will be conducted targeting the cluster participants.

In total, the ET plans to interview a maximum of 68 key informants, 6 group interviews mainly with community leaders and trainees and 12 FGDs with service recipients

#### 4 Process of analysis and developing conclusions

*Descriptive quantitative analysis:* This method will be applied to analyse programme outputs including beneficiaries accessing services offered with the programme support. Data will be disaggregated by age, sex and geographical location to the extent possible. The analysis will be done using excel to identify trends and proportions of target populations reached under each programme output. Financial data will also be analysed by comparing budgets and expenditure by year and programme objectives to assess financial absorption rates.

*Iterative qualitative analysis:* Iterative analysis will be conducted to analyse qualitative data from key informants, documents and focus group discussions. It will enable the evaluation team to connect and cluster qualitative data according to the evaluation questions. Each data cluster will be analysed to identify the initial emerging themes. The emerging themes from each cluster will be re-categorised to establish patterns of findings for each evaluation question.

*Triangulation:* Two types of triangulation will be applied: method triangulation where qualitative data will be used to gain insights into the results of the quantitative data analysis. Secondly, data sources triangulation will be conducted to examine consistency across data sources. This will include analysing consistency of emerging themes within the same category of stakeholders and across different categories of stakeholders. This approach minimises bias and strengthens evidence for evaluation findings.

#### 5. Conclusions and recommendations

The ET will derive conclusions logically by synthesising findings for each evaluation question. This will ensure conclusions can be traced from the evidence analysis and findings. The conclusions will be structured according to the OECD criteria – relevance, effectiveness, efficiency, and sustainability. Conclusions cutting across two or more criteria will also be identified if the findings support such conclusions.

Recommendations will also be derived from the conclusions. The ET will show clearly how each recommendation is logically linked to one or more conclusions. Furthermore, the recommendations will be actionable and ET will recommend the entity responsible for each recommendation. This will ensure the utility of the evaluation.

#### 6. Ethics and participation

The evaluation process will adhere to internationally recognised principles for good conduct. It will also be conducted in line with Tana's Ethical Guidelines, which encompasses the organisation's approach to human rights, labour conditions, the environment, anti-corruption and bribery, and the ethical values according to which

their staff and consultants are expected to conduct their work. It will also adhere to Tana’s Safeguarding Policy, which provides an outline of the organisation’s approach, practice, and commitment to “ensuring a comprehensively safe environment for all people that the organisation engages with”.

As such, the evaluation will need to be sensitive to gender, beliefs, manners, and customs of all stakeholders, and be undertaken with integrity and honesty and ensure the inclusiveness of views. Furthermore, the conduct of the evaluation team will ensure that the rights and welfare of participants, including the anonymity and confidentiality of individual informants, will be protected, in particular of direct beneficiaries and target communities. Anonymity will be ensured through to the reporting phase ensuring that data is aggregated and triangulated, thus ensuring individual responses cannot be traced. Key informants and FGD participants will be informed about the purpose of the evaluation and requested for their consent to participate. The ET will also make it clear that they have a right to withdraw at any point during the interview.

We will adhere to a strict Do No Harm approach – relative to individuals, institutions, implementing partners, and communities. The protection of primary and secondary beneficiaries and target groups will be of paramount importance.

#### 7. Limitations and mitigation measures

There are no major limitations of the methodology proposed for this evaluation. The COVID-19 pandemic has drastically reduced globally and in Bangladesh, as such the evaluation team is likely to access key informants and beneficiaries.

The key limitation is likely to be the time provided for primary data collection. The number of key informants and focus groups to be conducted based on the tentative stakeholder mapping shows that the ET may require more days for primary data collection. The ET proposes to mitigate this time limitation by further reprioritising people to be interviewed without compromising the robustness of evidence and also conducting virtual interviewing with some KIIs before or after the field data collection period.

In addition, there is a likelihood that some key informants may have moved from organisations participating in this programme, thus, making it difficult to access such stakeholders. This limitation will be mitigated through triangulating data from documents and several other stakeholders to build a solid evidence-base.

# Annex 4 – Data collection tools

## 5.1 Semi-structured interview guide - RHSTEP/BAPSA programme governance bodies, management and staff

Introduction	<ol style="list-style-type: none"> <li>1. What is your role in the programme?</li> <li>2. How has the MR programme evolved and progressed over time?</li> </ol>
Relevance	<ol style="list-style-type: none"> <li>3. How does the MR programme respond to SRHR needs of adolescent girls, women including women with disabilities and men?</li> <li>4. How were these needs identified? And who was involved in identification of needs and how?</li> </ol>
Effectiveness	<ol style="list-style-type: none"> <li>5. How did programme interventions contribute to better/quality SRHR service delivery? (i.e. service provider training, consortium capacity building, SRHR knowledge and information, monitoring/research, advocacy)</li> <li>6. What made it possible for target groups to access services provided through the programme - MR, PAC, LCC, diagnostics, training etc?</li> <li>7. What prevented target groups from accessing services provided through the programme?</li> </ol>
Efficiency	<ol style="list-style-type: none"> <li>8. How did the governance bodies (EC and PAB function? How did they contribute to improved programme implementation and achievement of results?</li> <li>9. How did RHSTEP and BAPSA management contribute to programme implementation and achievement of results?</li> <li>10. Did RHSTEP and BAPSA have required staff to manage and implement the programme? How, if not why?</li> <li>11. How does RHSTEP/BAPSA track programme activities and outputs? And how do you track SRHR data? How is your M&amp;E system linked to the government information system?</li> <li>12. To what extent has RHSTEP and BAPSA been able to disburse funds as per budget? Why/ why not?</li> <li>13. How was the programme adjusted in response to any changes that took place during implementation in respect to - human, financial, and environmental resources?</li> <li>14. What gaps and opportunities emerged during implementation? How did the programme take advantage of these opportunities to deliver better services?</li> <li>15. What challenges did the programme face during implementation?</li> </ol>
Sustainability	<p>If best practices/lessons were documented</p> <ol style="list-style-type: none"> <li>16. How were best practices and lessons used?</li> </ol>

	17. What plans are in place to implement the financial phase out strategy? (if the strategy is in place). What are the likely sources of funds, resource mobilisation approaches etc?
Cross cutting issues	18. What measures were taken to integrate gender equality and human rights-based approach into the programme? 19. What measures were taken to increase knowledge of SRHR among women, adolescent girls, men, community and religious leaders and other stakeholders? 20. What platforms were put in place for women to discuss and voice their needs and concerns in SRHR? How well did these platforms work and what were the challenges?

## 5.2. Service providers at clinics - Semi-structured interview guide

1. How long have you worked at the clinic?
2. What is your role at the clinic?
3. **Relevance: What problems in the community is the clinic addressing?**
4. **Effectiveness- services: What types of services are your providing in the clinic?**
  - Who are your main clients in terms of age, income and other factors?
  - In your view, what challenges do the women and girls face in coming to the clinics?
  - How do you decide who is charged and who is not? Any challenges in deciding who to pay or not to pay?
  - How do you get the medicines and supplies and other commodities you need?
  - What challenges are facing in providing services?
  - Have you ever gone without medicines and supplies? If so, how did this happen?
5. **Effectiveness – knowledge and awareness: Do you go or someone else from the clinic go out to the community, school or garment factories?**
  - Why do you make these visits?
  - How often do you do this in a month or quarter?
  - What do you do at the community, school or garment factory?
  - Who do you meet? How or who organises the community or garment factory workers or school students before you arrive?
  - What information do you provide?
  - In your view, what have been the achievements of these visits?
6. **Effectiveness – training**
  - Have you attended any training organised by BAPSA or RHSTEP?
  - Which training (s) and when?
  - How useful were the training?
  - How have you used the skills/knowledge gained from the training?

**7. Cross cutting issues – Gender**

- Have you been trained on gender issues? When?
- How do you address gender issues?
- Do you hold meetings with women to discuss their SRH problems?
- How are you reaching men? What services are you providing them?
- What challenges do you face in reaching men?

**8. Efficiency**

- Are you getting any support from the RHSTEP/BAPSA office? What type of support?
- How often does RHSTEP/BAPSA visit the clinic for supervision? What do they check/do when they visit?
- In your view, are there enough staff in the clinic to provide the services required?
- How do you keep information in the clinic? How do you send the information to the head office?
- What did you do in response to COVID-19? How did you protect yourselves and the clients from COVID-19?
- Are there any changes that have taken place in the clinic over the last 5 years? Which ones and why?
- What are the challenges in running the clinic? Or providing services in the clinic?

**5.3. Semi-structured interview guide – Medical college directors**

1. How are you collaborating with RHSTEP?
2. What support is the hospital providing to the RHSTEP clinic?
3. What type of services is the RHSTEP clinic providing?
4. In your view, does the RHSTEP have adequate staff to provide the service?
5. What can be done to improve RHSTEP clinic services?

**5.4. Semi-structured interview guide – the likeminded organization**

1. How are you collaborating with RHSTEP and BAPSA?
2. What support did they provide regarding the MR program?
3. What type of event you joined? Any meeting/workshop/training?
4. What support do you provide to BAPSA?
5. What contents are included in the training/meeting/workshop?
6. What is the follow-up process after the event?
7. Did you join any of their networking meetings?
8. Did you join any of their advocacy meetings?
9. What support is the Noakhali Hospital providing to you, especially the FPAB clients or any relevant stakeholders?
10. Do you have any idea what type of services are they providing?

11. In your view, do they have adequate staff to provide the service in the clinic?
12. Any challenges to conduct the collaboration?
13. What can be done to improve collaboration?

### **5.5 Adolescent and young people at Alodhara Pathshala FGD guide**

1. How did you learn about this AlorDhara Pathshala?
2. How often do you come here?
3. What activities do you do at this centre?
4. What have you learnt about sexual and reproductive health in this centre?
5. How have you used the knowledge gained? E.g. going to clinic for SRH services, use of condoms, etc.
6. Do you discuss what you have learnt with your friends or other youth?
7. Do you face any challenges coming to this centre?
8. Is there other SRH information you need that is not provided in this centre?
9. What can be improved at the centre?

### **Adolescent girls FGD?**

1. How did you learn about the services provided in the clinic?
2. What service did you seek from the RHSTEP clinic?
3. What type of service did the clinic provide?
4. How long did it take to get the service?
5. Did you pay for the service?
6. What challenges did you face in coming to the clinic?
7. What did you do to overcome the challenges?
8. Did you get support from your family or husband to come to the clinic? If so, which support?
9. Are there other girls with a similar problem who are not coming to the clinic? Where do they go for service?
10. Have you ever attended a meeting where sexual and reproductive health issues have been discussed? When was this? If not, where do you get information on SRH?
11. What are doing to avoid pregnancy if you want to?

## Annex 5 - Documentation consulted

1. National Institute of Population Research and Training (NIPORT) and MEASURE Evaluation, UNC-CH, USA. 2012. Bangladesh Maternal Mortality and Health Care Survey 2010
2. Bangladesh Health policy 2011
3. National Institute of Population Research and Training Ministry of Health and Family Welfare, 2016. Bangladesh Demographic and Health Survey 2014
4. Singh, S. et.al., 2017. The incidence of Menstrual Regulation Procedures and Abortion in Bangladesh, 2014
5. Hossain, A. et.al., 2017. Access to and quality of menstrual regulation and post abortion care in Bangladesh: Evidence from a survey of health facilities, 2014. Guttmacher Institute.
6. Guttmacher Institute, 2012. Menstrual regulation and induced abortion in Bangladesh, factsheet.
7. Guttmacher Institute, 2012. Menstrual regulation, unsafe abortion and maternal health in Bangladesh. In brief series 2012, No.3
8. Huda, F, A., et al., March 2017. Introduction and approval of menstrual regulation with medication in Bangladesh: A stakeholder analysis. Icddr,b.
9. Mango, 2009. How healthy is financial management in your not-for-profit organisation?
10. Vlassoff, A. et.al., 2012. Menstrual regulation and post abortion care in Bangladesh: factors associated with access to and quality of services.
11. Bangladesh Ministry of Health and Family Welfare, 2016. Health, Nutrition and Population Strategic Investment Plan (HNPSIP) 2016-2021. Guttmacher Institute.
12. Bangladesh Ministry of Health and Family Welfare (MOHFW) Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS) and Directorate General of Nursing and Midwifery (DGNM), 2021. National Comprehensive Menstrual Regulations Guidelines.
13. Bangladesh Ministry of Health and Family Welfare (MOHFW) Directorate General of Family Planning (DGFP), National Comprehensive Menstrual Regulations and Post-Abortion Care Services Guidelines.
14. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Health Service Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Community Based Health Care (CHBC) Operational Plan, 2017-2022.
15. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Communicable Disease Control, Operational Plan, 2017-2022



16. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Health Service Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Health Information System and e-health, Operational Plan, 2017-2022.
17. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Health Service Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Lifestyle and Health Education and Promotion, Operational Plan, 2017-2022.
18. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Medical Education and Welfare Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Medical Education and Health Manpower Development, Operational Plan, 2017-2022.
19. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Health Service Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Maternal Neonatal Child and Adolescent Health, Operational Plan, 2017-2022.
20. Bangladesh Ministry of Health and Family Welfare, Directorate General of Health Services, Health Service Division, 2017. 4<sup>th</sup> Health, Population and Nutrition Sector Programme, Non-Communicable Disease Control, Operational Plan, 2017-2022.
21. Bangladesh Ministry of Health and Family Welfare, 2016. National Strategy for Adolescent Health 2017-2030
22. Bangladesh Ministry of Health and Family Welfare, 2019. National Strategy for Maternal Health 2019-2030
23. RHSTEP and BAPSA, October 2016. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Programme document July 2017 to June 2021
24. RHSTEP and BAPSA, March 2019. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Revised quantitative activity and revised budget, October 2017 to September 2021
25. RHSTEP and BAPSA, March 2020. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Revised quantitative activity and revised budget, October 2017 – December 2021
26. RHSTEP and BAPSA, March 2021. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Revised quantitative activity and revised budget, October 2017 to December 2021
27. RHSTEP and BAPSA, October 2021. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project) phase II, January to December 2022

28. RHSTEP and BAPSA, November 2019. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report October 2017 – September 2018
29. RHSTEP and BAPSA, November 2019. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report October 2018 – September 2019
30. RHSTEP and BAPSA, November 2020. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report October 2019 – September 2020
31. RHSTEP and BAPSA, November 2021. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report October 2020 – September 2021
32. RHSTEP and BAPSA, 2022. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report October – December 2021
33. RHSTEP and BAPSA, February 2023. Strengthening of safe MR and Family Planning services and reduction of unsafe abortions for improving SRHR situation in Bangladesh (Safe MR Project), Combined yearly report January – December 2022
34. Evaluation report on the comprehensive reproductive and sexual health programme including MR services and training supported by Sida, 2014.
35. A report on assessment of the SRHR programme 2014-2016
36. Embassy of Sweden, 2017. Institutional and financial management capacity of RHSTEP.
37. National Institute of Population Research and Training (NIPORT) and MEASURE Evaluation, UNC-CH, USA. 2012. Bangladesh Maternal Mortality and Health Care Survey 2016
38. National Institute of Population Research and Training, Medical Education and Family Welfare Division Ministry of Health and Family Welfare, 2020. Bangladesh Demographic and Health Survey 2017-18
39. National Institute of Population Research and Training (NIPORT) and MEASURE Evaluation, UNC-CH, USA. 2012. Urban Health Survey, 2021
40. National Institute of Population Research and Training, Medical Education and Family Welfare Division Ministry of Health and Family Welfare, 2020. Bangladesh Demographic and Health Survey 2022
41. RHSTEP, 2022. Gaps in perception in SRHR, barriers to safe MR and post abortion care services and related gender- based violence in poor young women in Dhaka slums: A comprehensive study

42. RHSTEP. Cervical Cancer Prevention Practice among Slum Women in Dhaka City: A Cross-sectional Study
43. Sida. Country Profile: on universal access to sexual and reproductive rights: Bangladesh

## Annex 6 – List of Interviewees

Name	BAPSA	RHSTEP	Govt.	NGO/ Garment	Clinic	Community (Boys/girls/ men/women/ pharmacists)	Sida	Level
Zahir Islam							*	National
Prof. Dr. Kohinoor Begum		*						National
Dr. Sabera Rahman		*						National
Quazi Suraiya Sultana		*						National
Altaf Hossain, Ph.D	*							National
Dr. Manjur Hossain			*					National
Medical Officer at MCD, Dhaka					*			National
Clinic medical staff - nurses, FWV, paramedics					*			National
Adolescent girls FGD - MCD, Dhaka						*		National
Women FGD - MCD, Dhaka						*		National
Men FGD - MCD, Dhaka						*		National
Youths FDG						*		National
Dr. Laboni Akter, Clinic Manager (MRHC-2)					*			National
Nargis Ara Banu, Counselor					*			National
Sonia D Costa, Paramedic					*			National
Taslima Khanam, Field Supervisor, Mirpur					*			National
Adolescent girls FGD - Mirpur, Dhaka						*		National
Men FGD - MCD, Dhaka						*		National
Women FGD - MCD, Dhaka						*		National

# ANNEX 6 – LIST OF INTERVIEWEES

Kazi Nurul KabirNuru Head Master, E-Ideal High School						*		National
Mohammad Abu, Community Leader						*		National
Abu Sufian, Noakhali				*				District
Abula Kalam Azad, Project Coordinator, Noakhali,					*			District
Dr. Nurul Alam, FPAB- Noakhali				*				District
Md. Masudul Haque		*						National
Medical Officer, Sylhet MAG Osmany Medical College Hospital				*				District
Director, Sylhet M A G Osmany Medical College Hospital Head of Gyn and Obs, Sylhet M A G Osmany Medical College Hospital				*				District
RHSTEP Staff at SOMCH, Sylhet + Paramedic SOMCH				*				District
Mr. Abul Mansur Asjad, Upazila Family Planning Officer, Sylhet			*					District
Md. Sifot Ali, Principal, Ragib Rabeya High School and College, Lamakazi, Sylhet						*		District
Junior Youth officer, Alordhara		*						District
Adolescent girls FGD						*		District
Women FGD						*		District
Men FGD						*		District
Umme Kulsum, Mahtabpur, Lamakazi, Sylhet.						*		District

# ANNEX 6 – LIST OF INTERVIEWEES

A group of participants of different ages and sex in Alordhara Pathshala, Sylhet						*		District
Medical Officer					*			District
BAPSA Clinic In-charge - Dr.Makamum Mahmuda Clinic Inchage, Board Bazar (MRHC-6) Rezina Akter, Paramedic)					*			District
Service providers - BAPSA clinic staff					*			District
BAPSA trainees - Minara Begum, FWV, Gazipur					*			District
Community leader						*		District
Community leaders' group						*		District
Garment workers						*		District
Community men						*		District
Women of Reproductive Age						*		District
Mohammad Aman Ullah, DD, Dhaka			*					National
Abdullah al Hadi, Thana Family Planning Officer, Mirpur, DGFP			*					National
Farzana Begum, Welfare officer, Apollo knitwear limited, Mirpur				*				National
Morsheda Binte Asin, Head Mistress, Ibrahimpur Salauddin Shikkhalay, Mirpur						*		National
Dr. Bilkis Begum, Coordinator, OCC, Dhaka Medical College Hospital			*					National
Md. Mahbubul Haque		*						National
Dr. Elvina Mustary		*						National

# ANNEX 6 – LIST OF INTERVIEWEES

Ms. Sangita Debnath (Asst. Manager, Procurement)		*						National
Ms. Shamsun Nahar (Asst. Manager, Logistics supply)		*						National
Ms. Parvin Akter (Admin officer)		*						National
Mr. Abul Kashem (IT officer)		*						National
Hadayeat Ullah Bhuiyan		*						National
Mr. Bivash Kanti Biswas (Deputy Director, Finance)	*							National
Mohiuddin Khan Manager (Accounts & Finance)	*							National
Nazma Akter Store In-charge	*							National
Md. Kawser Karim Program Coordinator	*							National
Mostafizur Rahman Manager (HR & Training)	*							National
Mr. Bazlul Karim (Manager, Audit)		*						National

# Annex 7 – Output 5 indicator targets against results

	No. of research/study conducted on selected issues including Client exit interview in each six months			No. of regular and need based monitoring visits held by the different management authorities			Monthly/quarterly/Annual meetings held at all consortium centres including H/O			AGM, EC and other committee meetings held accordingly		
	Target	Result	%	Target	Result	%	Target	Result	%	Target	Result	%
2017/18	2	1	50%	170	82	48%	260	229	88%	14	13	93%
2018/19	3	5	167%	148	184	124%	216	253	117%	14	14	100%
2019/20	5	3	60%	143	120	84%	175	177	101%	14	11	79%
2020/21	2	2	100%	143	63	44%	190	253	133%	14	15	107%
Oct-Dec 2021				33	17	52%	34	58	171%	2	0	0%
2022	2	2	100%	176	98	56%	233	334	143%	16	13	81%
	No. of TAC meeting held			No. of regular meeting held with consortium members i.e. PAB			Audits conducted in each year			Necessary equipment and logistic procured; A learning sharing session organised at the end of the project		
	Target	Result	%	Target	Result	%	Target	Result	%	Target	Result	%
2017/18				3	3	100%	2	2	100%			
2018/19				3	2	67%	4	3	75%			
2019/20				3	2	67%	4	3	75%			
2020/21				3	2	67%	4	4	100%			
Oct-Dec 2021												
2022				3	3	100%						



# Annex 8 – RHSTEP and BAPSA planned unit cost compared to actual unit cost per activity

Budget Line Item (Costs in Taka)	BAPSA				RHSTEP			
	Budgeted unit cost (A)	Expenditure unit cost (B)	Variance (Budgeted vs Actual unit cost) (A-B=C)	% of variance (C/A=D)	Budgeted unit cost (E)	Expenditure unit cost (F)	Variance (Budgeted vs Actual unit cost) (F-E=G)	% of variance (G/E=H)
Services	409.86	707.17	-297.31	-73%	741.49	735.98	5.51	1%
MR/MRM/PAC Services	478.64	896.7	-418.06	-87%	801.9	1066.85	-264.95	-33%
RTI/STI Services	345.77	555.66	-209.89	-61%	355.86	234.56	121.3	34%
Training (including module development)	20392.69	23178.02	-2785.33	-14%	36580.59	25861.27	10719.32	29%
MR/MRM Training (Doctor, Nurse, Paramedics)	50000	-		0%	81799.28	81388.93	410.35	1%
MR/MRM Refresher Training (Doctor, Nurse, Paramedics)	44402.86	63962.89	-19560.03	-44%	30106.68	30117.16	-10.48	0%
Training for community volunteers and Peer Educators	15080.22	17216.93	-2136.71	-14%	1000	505.94	494.06	49%
Staff Capacity Development Training	10944.44	11011.92	-67.48	-1%	11394.74	8797.36	2597.38	23%
Outreach/BCC Activities for dissemination information of safe service /Publicity through Bill Board, Sign Board	5.85	6.18	-0.33	-6%	62.87	0	62.87	100%
Awareness on Community Level	2.61	2.83	-0.22	-8%	1303.39	1750.15	-446.76	-34%

# ANNEX 8 –RHSTEP AND BAPSA PLANNED UNIT COST COMPARED TO ACTUAL UNIT COST PER ACTIVITY

awareness on SRHR through Publicity (Leaflet/Poster etc.)	11.9	10.81	1.09	9%	25.05	23.27	1.78	7%
Initiate Service at Communities through Mobile Phone	315.81	125.55	190.26	60%	610.97	690.36	-79.39	-13%
Round Table Discussion/ TV Talk Show	-	-			250000	304078.53	-54078.53	-22%
Community Visit	2.76	3.09	-0.33	-12%	1221.93	2580.71	-1358.78	-111%
Orientation/Meeting with Gatekeepers/ CSG Meeting	14379.4	22725.42	-8346.02	-58%	10416.67	5974.72	4441.95	43%
Publication of Journal/Newsletter	25000	-		0%	-	-		
Observation of National & International Day	30479.44	30300.58	178.86	1%	13613.03	23303.82	-9690.79	-71%
Seminar/Dialogue/ Workshop/Conference	22249.54	22479.89	-230.35	-1%	414500	80663.81	333836.19	81%
Divisional/District Level Workshop	460880	422931.19	37948.81	8%	652057.5	332012.23	320045.27	49%
Workshop/Seminar with Garments Authority	27433.33	28770.83	-1337.5	-5%	75000	65796.74	9203.26	12%
Workshop with Adolescent & CSG	4817.56	4833.5	-15.94	0%	-	15135.95		

Source: RHSTEP and BAPSA Unit Cost Analysis

Note: Negative variance means the actual unit cost is higher than budgeted unit cost and positive variance means the unit cost is lower than budgeted unit cost

## Annex 9 – Donor funding for RHSTEP and BAPSA

<b>BAPSA</b>				<b>RHSTEP</b>	
<b>Donor &amp; Start and End Date</b>	<b>Budget</b>	<b>Donor: Start and End Date</b>	<b>Budget</b>	<b>Donor</b>	<b>Budget (in BDT)</b>
Asian Development Bank, Government of Bangladesh: 2000 – 2024	590,343,580	NIPORT: 2022-2023	44,760,000	Health Bridge Foundation of Canada: 2021-2025	35,360,611.00
Guttmacher Institute, USA: 2020 – 2023	6,655,211	IPPF: 2018-2019	12,392,056	The David & Lucile Packard Foundation: 2021-2023	13,596,461.00
ARROW: 2018 – 2023	12,095,341	RFSU: 2010-2018	55,610,776	Ipas North Carolina: 2022-2023	4,490,844.00
Ipas, Bangladesh: 2021 – 2025	81,498,947	IPPF through SAAF: 2011-2014	25,665,175	Ipas Global: 2021-2023	34,540,361.00
Ipas, Bangladesh: 2020 – 2022	8,926,013	EKN: 2016-2020	37,781,227	Rutgars: 2023-2025	10,291,003.00
Ipas, Bangladesh 8/08/2023 2017 – 2022	175,703,941	EKN: 2016-2020	61,591,649	<b>Total</b>	<b>98,279,280.00</b>
GFATM: 2006-2023	47,253,006	Unicef: 2015-2021	26,559,250		
<b>Total</b>			<b>1,186,836,172</b>		



## Final Strengthening of Safe MR and Family Planning Services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe Menstrual Regulation (MR) programme)

This report presents an evaluation of the Strengthening of Safe MR and Family Planning services and Reduction of Unsafe Abortions for Improving SRHR Situation in Bangladesh (Safe MR programme) from 2017 to 2022. It aims to assess the programme's alignment with Sida's SRHR priorities, effectiveness, efficiency, sustainability, and gender integration. The evaluation found the programme relevant to SRHR needs but lacking clear approaches for marginalized groups. It identified effective training initiatives and early stages of gender integration, but sustainability remains a concern without a financial plan. The team identified concerns that include inadequate staffing, limited outreach to marginalized groups, and sustainability challenges. The report recommends scaling up community interventions, strengthening gender integration, improving advocacy strategies, enhancing staffing, developing a financial sustainability plan, and investing in research and organizational development for sustainability.

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