A mid-term review (MTR) of the project to strengthen the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh was held in Dhaka in November-December 2010. The review evaluated the progress in project implementation, the achievements made and the challenges experienced by different stakeholders.

This report of the mid-term review highlights findings and recommendations for the government and WHO. Recommendations were also made for the partners implementing projects funded by the Challenge Fund to further strengthen the menstrual regulation programme and related services in Bangladesh.
Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh

27 November – 11 December 2010
Dhaka, Bangladesh

Mid-Term Review Report
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Acknowledgements

This document is a report of the Mid-Term Review of the “Strengthening National Menstrual Regulation Programme for Reduction of Maternal Morbidity and Mortality” Project launched by the World Health Organization Country Office for Bangladesh in collaboration with the Government of Bangladesh and with financial support from the Embassy of the Kingdom of the Netherlands in Bangladesh.

The MTR team would like to thank all participants and representatives from the Directorate General of Family Planning, Ministry of Health and Family Welfare of Bangladesh, the Embassy of the Kingdom of the Netherlands, and all implementing agencies for the MR projects who participated in the review and experience-sharing workshop. We would like to acknowledge the implementing partners who presented their respective project reports and all participants who commented on the presentations. We would also like to express our gratitude for a well-prepared schedule of field visits which allowed the MTR Team to observe a comprehensive range of activities. Thanks are due to all the resource persons who provided information to our team regarding the Project. Finally, the objectives of the MTR would not have been achieved without the assistance of the Technical Officer, Maternal Health of WHO Country Office, who arranged and facilitated the workshop, meetings and field visits at the project sites.

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Executive summary

The Initiative “Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh” was launched by the World Health Organization (WHO) Bangladesh with financial support from the Embassy of the Kingdom of the Netherlands. The overall purpose of this Initiative on Menstrual Regulation (henceforth termed the MR Initiative 1) is to improve equitable access to quality MR services for the prevention of unsafe abortion and unsafe MR. The MR Initiative has a particular focus on the poor and underserved groups in rural, urban and hard-to-reach areas of Bangladesh. To achieve the aims of the Initiative, two Calls for Proposals were announced. Three proposals were selected in the first call in 2008 and five in 2009. The total size of the grant for the MR Initiative over a four-year period (2007-2011) is US$ 3.932 million, and the funds for the implementation (referred in the Project document as a “Challenge Fund”) by NGOs and research institutions are US$ 2.73 million.

The objectives of the Mid-Term Review (MTR) were to identify the strengths and weaknesses of the interventions funded by the Initiative and the progress of the implementation and challenges experienced by different stakeholders. The findings of the MTR will serve as the basis for recommendations for improving the implementation of the projects and suggestions to build on the MR initiative to strengthen the national MR Programme and services in Bangladesh.

Rapid assessment methods were used. Taking a qualitative approach to this formative review, the MTR team reviewed project documents, progress reports, information, education and communication (IEC)/behavioural change communication (BCC) materials developed within the framework of the MR Initiative. The team interacted with the stakeholders implementing the projects, in a national workshop as well as in meetings and interviews during site visits. Meetings and discussions were held with local representatives of the stakeholders and beneficiaries during field visits to the project sites. Observations of group meetings, educational

1 The project “Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh” is referred throughout this report as “MR Initiative” or as “MR Project” interchangeably. This is to be distinguished from “project(s)” which are grants implemented within the Challenge Fund of the MR Initiative by the MR NGOs and ICDDR,B.
sessions and service provision were also carried out. Representatives of the Directorate General of Family Planning (DGFP) and WHO provided inputs on the overall project implementation and management and the progress of projects by implementing partners.

I. Project Governance by the Directorate General of Family Planning

The Project is under the leadership of the Directorate General of Family Planning (DGFP) which was actively involved in identifying project areas to reach marginalized populations. In addition, the DGFP provided guidance and coordination of the project implementation through the designation of the Technical Advisory Committee (TAC), the Coordination Committee for MR agencies in Bangladesh (CCMR,B); and a Working Group for final review of applications for funding. The DGFP is responsible for providing contraceptive supplies and commodities, MR services in the public sector, and management of referrals of complicated cases from NGO clinics. Services for MR conducted by NGOs complement the programmes in the government-run clinics.

II. Project management by the World Health Organization

WHO is responsible for executing, managing and providing technical assistance to a project implemented by many NGOs and a research institution. Technical support of WHO for NGOs is seen in five areas: 1) review and feedback on concept papers and then on full proposals and for proposal finalization during a workshop; 2) development of IEC/BCC materials; 3) project implementation; 4) report writing; and 5) development of national guidelines for MR services. Procurement of office equipment for the projects and printing of IEC/BCC materials was done by the WHO Country Office. Project management included review of the quarterly financial and technical progress reports submitted by the implementing partners, monitoring visits to the different project sites and provision of feedback to the NGO partners. The WHO country office recruited a professional staff member, (Technical Officer, Maternal Health (TO-MH)) to coordinate the project.
III. Implementation of Projects by MR Partners

The proposals funded by the Challenge Fund related to the four components identified in the call: (i) scaling up delivery of quality MR services; (ii) enhancing rights-based demand generation for safe MR services; (iii) improving the knowledge and evidence base on sexual reproductive health and right issues; and (iv) strengthening of policy responses. The majority of the projects submitted and approved for funding were on raising awareness in the community and demand generation to prevent unwanted pregnancies and to improve equitable access to safe, high quality MR services among the poor and underserved population. Community and clinic activities were emphasized.

The proposals from Light House, Shushilan and the Marie Stopes Clinic Society were funded in the first call for proposals. The proposals from Phulki, Family Planning Association of Bangladesh, Bangladesh Association for Prevention of Septic Abortion and a second proposal from Marie Stopes Clinic Society were funded in the second call. A research project submitted by ICCDR, B, a research centre, was also supported in the second call.

Summary of activities conducted

The success of activities was enhanced by the existing strong relationship between the NGOs and the community and active participation by each community group. The NGOs built on their prior experiences in providing information and services on sexual and reproductive health (SRH), family planning (FP) and MR.

Enhancing rights-based demand generation for safe MR services

Uniform messages and IEC/BCC materials developed through the MR Initiative and approved by DGFP, NGOs and WHO have been used by all implementing partners. Local volunteers were trained to be community educators, community mobilizers, peer educators, reproductive health promoters or health educators. A wide range of representatives of community groups is involved, e.g. female community social group members, local leaders, elected female representatives, microcredit NGO members, teachers and key decision-makers at the local level. A pool of master trainers for each NGO, drawn from central and other levels of the respective organizations, conducted training for the community educators.
on reproductive health and the rights-based approach to information and services.

*Scaling up delivery of quality MR services*

Service delivery also employed several modalities based on the existing situation, and the collaboration with public sector was strengthened. Marie Stopes Clinic Society (MSCS) and Family Planning Association of Bangladesh (FPAB) provided both MR and FP services in collaboration with service providers, i.e. female welfare visitors (FWV) and female welfare assistants (FWA).

Two NGOs signed a Memoranda of Understanding with private hospitals (Light House with Khulna Mukti Sheba Sangsth (KMSS) clinic and Shushilan with Nalta Hospital). These facilities provided the pre- and post-MR counseling and MR services, while FP services were provided by FWAs. Phulki and Bangladesh Association for Prevention of Septic Abortion (BAPSA) provided counseling and information on facilities available for safe MR and FP services. As per established procedures, women were referred to nearby public hospitals if they experienced complications after MR services.

**IV. Overall implementation by the MR Initiative**

The MR Initiative has achieved the goals of wide geographic coverage and reaching diverse target groups who are poor and marginalized, and therefore underserved. The IEC/BCC materials used in the project provided clear and consistent messages on safe MR (“right place, right time and right person”), family planning, post-MR contraception, prevention of early marriage and prevention of violence against women. Private public partnerships have been established in a formal and informal manner.

*Component 1: Scaling up delivery of quality MR services*

Availability of competent/trained staff, supplies, infection prevention procedures and a functioning referral system contribute to quality of care. The non-judgemental attitude of providers with good communication and interpersonal skills is critical for MR services.
The quality of MR services remains a challenge. A key issue is a shortage of providers in the public sector. The reuse of MR equipment was noted during the field visits, while guidelines for re-use of cannulae and aspirators were not always strictly followed. In some instances, the non-formal fee for services in both private and public sectors was brought up. Underreporting of MR procedures at district and sub-district levels is a challenge for reporting and has implications for procurement of supplies and equipment for MR and contraceptives and commodities for family planning.

Component 2:- Enhancing rights-based demand generation for safe MR services

Demand generation by the different NGOs to diverse target groups in wide geographic areas was accomplished through standardized IEC/BCC materials developed in a participatory manner. The IEC/BCC messages were communicated using multi-pronged approaches: (a) different platforms (meeting, drama/songs, written messages in poster/leaflet/brochure formats, and face-to-face communication); (b) diverse target audiences (adolescents, community women, and mixed groups of men and women); and (c) other approaches (sensitization meetings, strengthening messaging through repeat sessions, or dissemination of only one key message at a time over regular intervals with the same group while reinforcing earlier messages).

Component 3: Improving the knowledge and evidence base on unsafe abortion, MR, and other sexual and reproductive health and rights issues

The number of research proposals submitted for funding is limited. A proposal on sociocultural aspects and women’s perceptions of menstrual regulation and menstrual regulation services in Bangladesh has been funded. Baseline surveys were conducted using standard questionnaires and the planned end-line surveys will contribute to the knowledge-base on unsafe abortion, MR, and other sexual and reproductive health and rights issues.
Component 4: Strengthening the policy response

While the implementation of the MR Project in many areas of the country for diverse population groups is a positive start, the broader framework and strategies for scaling up will need to be considered. Although some mechanisms for sustainability have been built into the project, political commitment and funding will be required to build on the gains made to ensure that the rights-based approach to SRH information and services continues.

Recommendations

DGFP should build on the momentum gained through this Initiative to strengthen the national MR programme through (i) establishing/monitoring quality improvement processes for safe MR services; (ii) institutionalizing IEC/BCC materials focussing on a rights-based approach to safe MR and FP services; and (iii) strengthening human resources by recruitment and development and the skills of service providers, particularly FWAs and FWVs to contribute to availability of quality MR services.

WHO should build on the collaboration established with DGFP and NGOs and review activities under each component with these partners for the remainder of the project period. As a technical and managing agency, WHO is to take into consideration a start-up period for administrative and financial procedures and to include contingency or other mechanisms in the planned budgets to address legitimate unforeseen expenditures.

The findings related to the implementing agencies (NGOs) emphasize the need for continuation of cross-organizational leaning among the NGOs. This includes sharing of IEC/BCC activities for diverse population groups with different levels of literacy and knowledge of reproductive health. The participatory and interactive approaches used by these NGOs to reach out and disseminate information to women should be continued and enhanced. Also the other approaches such as drama and songs were employed for groups with low literacy should also continue and be enhanced. These approaches should be well-documented as they constitute an array of methods that could be used in future activities for various groups.
The difference in service infrastructure and competency of MR providers, infection prevention procedures, availability of supplies resulted in varying degree of quality of MR services. MR Initiative in Bangladesh is based on public-private partnership and improvements in quality of services can not be achieved by any party alone. Recognizing the need for major policy input to strengthen the human resource capacity, both in numbers and in skills to improve coverage and quality of service, DFGP plans re-starting recruitment and training of Family Welfare Visitors (FWVs). MTR team also recommends that every effort to be made to provide MR and FP services at a “one-stop” centre to improve service outcomes.

Monitoring including better collection and management of data and information is another area that needs to be strengthened. Feedback which is crucial for successful implementation followed by sharing of experiences among NGOs is to be encouraged.

In conclusion, the majority of the projects have progressed well within the short time-frame. Public private partnerships have been strengthened and vulnerable populations targeted. Clear and consistent messages focussing on preventing unsafe abortion and safe MR services have been developed and widely disseminated. Despite the achievements; DGFP, NGO partners and WHO recognized challenges in implementing the project, particularly in relation to human resources and supplies and equipment for MR, contraceptive supplies and commodities. To ensure the sustainability of the Initiative, political commitment and allocation of funds will be required to ensure that the rights-based approach to SRH information and services continues. The Initiative was able to generate a momentum which should be taken forward under the enhanced leadership of DGFP in collaboration with MR partners. A policy and programmatic dialogue and the development of a formal scaling-up strategy would be useful to sustain results and enhance the progress.
List of acronyms

BAPSA Bangladesh Association for Prevention of Septic Abortion  
BCC behavioural change communication  
BGMEA Bangladesh Garments Manufacture and Exporters Association  
BKMEA Bangladesh Knitwear Manufacture and Exporters Association  
CCMR, B Coordination Committee for MR Agencies in Bangladesh  
CIC Community-level Information Centre  
CRC Contract Review Committee  
DDFP Deputy Director (Family Planning)  
DGFP Directorate General of Family Planning  
DGHS Directorate General of Health Services  
DSF demand-side financing  
FCSG female community support group  
FIGO International Federation of Gynaecology and Obstetrics  
FP family planning  
FPAB Family Planning Association of Bangladesh  
FWA family welfare assistant  
FWV family welfare visitor  
H&FWC Health and Family Welfare Centre  
HA health assistant  
IEC information, education and communication  
ICDDR, B International Centre for Diarrhoeal Disease Research, Bangladesh  
KAP knowledge, attitude, practice  
KMSS Khulna Mukti Sheba Sangtha  
LMP last menstrual period  
MSCS Marie Stopes Clinic Society  
MA management agency
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<th>Abbreviation</th>
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<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MoU</td>
<td>memorandum of understanding</td>
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<td>MR</td>
<td>menstrual regulation</td>
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<td>MSM</td>
<td>men having sex with men</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OGSB</td>
<td>Obstetrics and Gynaecology Society of Bangladesh</td>
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<td>PMC</td>
<td>Project Management Committee</td>
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<td>RHP</td>
<td>reproductive health promoter</td>
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<td>RHSTEP</td>
<td>Reproductive Health Services Training &amp; Education Program</td>
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<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<td>STI</td>
<td>sexually transmitted infections</td>
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<tr>
<td>TBA</td>
<td>traditional birth attendant</td>
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<tr>
<td>TO MH</td>
<td>Technical Officer for Maternal Health</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>VAW</td>
<td>violence against women</td>
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<td>VCT</td>
<td>voluntary counselling treatment</td>
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<td>WHO CO</td>
<td>World Health Organization Country Office</td>
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<td>WHO-SEARO</td>
<td>World Health Organization South-East Asia Regional Office</td>
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1. Introduction

1.1 Relevance to the country context

Bangladesh has a large population of 146.6 million\(^2\) of which approximately one-fourth are women of reproductive age (15-49 years old).\(^3\) Although the maternal mortality ratio (MMR) has declined dramatically, it is still high at 338 per 100 000 live births in 2008.\(^4\) High MMR is mainly due to obstetric causes and reflects poor availability and low utilization of obstetric services, as well as lack of access to information. One quarter of all maternal deaths in Bangladesh were due to induced abortion.\(^5\)

The Government of Bangladesh introduced MR services on a limited scale in 1974 in a few isolated urban government family planning clinics. Legalization of MR took place in 1979; the government of Bangladesh considers MR to be “an interim method of establishing non-pregnancy for women who are at risk of becoming pregnant irrespective of whether conception has occurred or not”\(^6\). Hence, it is usually done without a pregnancy test. MR services using manual vacuum aspiration (MVA), are officially provided within eight to ten weeks since the last menstrual period (LMP). Existing information suggests that each year about 2.8% of all pregnancies result in MR and about 1.5% result in induced abortion, despite availability of family planning methods. Unsafe termination of pregnancies mostly occurs in rural areas where there is lack of awareness, knowledge and access to legal MR services.

\(^1\) BBS 2009  
\(^2\) National Population Census 2001  
Currently, MR services are provided through the public (Maternal and Child Welfare Centres, Upazila Health Complexes and Health and Family Welfare Clinics) and private entities. Non-governmental organizations (NGOs) are playing a vital role in both service delivery and awareness-raising activities. These efforts have resulted in improved access to safe MR services and post-MR family planning counselling and services. However, many women still have an unmet need for FP and MR information and services. The need is greatest for marginalized populations: women in urban slums, the rural poor and young girls. When access to formally established MR services is limited, women tend to seek aid from other sources, such as untrained and illegal providers, and often under unsafe conditions.

The MR services are performed by a Family Welfare Visitor (FWV), a female paramedic trained by the Ministry of Health and Family Welfare (MOHFW) at the Union Health and Family Welfare Centres (H&FWCs). However, the utilization of safe MR services at H&FWCs remains low, especially among high parity and less educated rural women. Although MR services at public facilities should be free, hidden/unofficial costs related to MR are an important deciding factor in inducing women to seek abortion services from traditional practitioners, as they are relatively inexpensive and services can be provided at home.

Economic, cultural and social barriers limit women’s access to safe MR services. Due to lack of awareness of the magnitude of risks related to unsafe MR, women often seek services from untrained providers and suffer from complications which sometimes might lead to death. In addition, quality of MR services, plays an important role in the decision-making to utilize services. To maintain high standards of quality of services the essential prerequisites are competencies and skills of providers, adequacy of supplies and equipment, and an information base for epidemiological data and monitoring.

Therefore, there is a critical need to strengthen the national MR programme with a focus on policy and programmatic aspects to address the issues of inequitable access and to ensure quality of care. With the financial support from the Netherlands Ministry of Development Cooperation and in partnership with the Government of Bangladesh and menstrual regulation NGOs (MR NGOs), the Initiative “Strengthening the National Menstrual
Regulation Programme for Reduction of Maternal Morbidity and Mortality in Bangladesh” was launched by WHO for the period of December 2007 – December 2011.

1.2 Purpose and objectives of the Project

The overall purpose of the Project7 “Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Morbidity and Mortality in Bangladesh” is to improve equitable access to quality and safe MR services, especially for poor and underserved women in urban, rural and hard-to-reach areas. The Project targets four closely interlinked components: (i) scaling-up delivery of quality MR services; (ii) generating rights-based demand; (iii) improving the knowledge and evidence base on sexual reproductive health and family planning; and (iv) strengthening the policy response.

1.3 Design of the Project

Under this Initiative, a Challenge Fund of US$ 2.73 million was established to support innovative project proposals from research institutions, MR NGOs and other potential partners on a competitive basis. The Challenge Fund supports grants to NGOs and research institutions based on a competitive call for proposals to test innovative approaches for MR service delivery and demand generation for sexual and reproductive health (SRH), family planning (FP) and MR. This project is implemented through the WHO Country Office (WHO CO) in Bangladesh as the dedicated management agency (MA), which manages the project including all liaisons and technical and supervisory aspects. WHO coordinates the project activities in collaboration with the Ministry of Health and Family Welfare, under the leadership of the Directorate General of Family Planning (DGFP).

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7 For the purpose of this report, the Initiative “Strengthening National Menstrual Regulation Programme for Reduction of Maternal Morbidity and Mortality in Bangladesh” is referred to as “MR project”, “MR Initiative” or “the Project” interchangeably.
1.4 Mid-Term Review of the MR Project

A requirement of the donor for this project is to conduct reviews and assessments on a regular basis. As per the Project document a mid-term and end-of-project evaluation are envisaged. The objectives of the MTR were to review the progress in Project implementation, achievements and challenges experienced by different stakeholders. Based on these findings, recommendations for steering the implementation of the projects funded by the Challenge Fund and suggestions for follow-up and strengthening of the MR programme and services in Bangladesh were made.

2. Methodology

Recognizing the complexity of the project management and the role of various implementing partners, the MTR review was organized to assess:

- The performance of DGFP on project governance
- The performance of WHO on project management,
- The overall MR Initiative as well as progress of projects by implementing partners (MR NGOs and ICDDR,B)

This conceptual framework is presented in the Figure 1.

The MTR aims to the effectiveness of governance, management processes and the implementation progress of the Project. The approach employed for this review was the use of qualitative methods. Nonetheless, each of the eight on going individual projects under the Challenge Fund has been continuously monitored quantitatively through specific process indicators, e.g. number of information and education materials printed and distributed, number of people in the community sensitized, number of women accessing the services, and number of referral cases. However, the scope of this report does not cover these detailed assessments, which are available in the individual project progress reports.
Rapid assessment methods were used. Taking a qualitative approach to this formative review, the following methods were employed. A document review included the review of project documents, progress reports, and IEC, BCC materials developed within the framework of the Initiative. A workshop of MR stakeholders at the national level was held at the start of the MTR. Meetings, observations and interviews with MR stakeholders and beneficiaries were conducted during field visits to project sites. The areas of project governance by DGFP, project management by WHO, the progress of the MR Initiative as a whole as well as the projects by implementing partners (MR NGOs and ICDDR,B) were evaluated using the criteria in the assessment tools (Annex A). The time-frame of MTR was a total of four weeks; with two weeks of field visits (from 27 November 2010 to 8 December 2010) and two weeks for document review and report preparation in December 2010 (Annex B for schedule of MTR).

A workshop for review and sharing of experiences among MR partners was held on 28 November 2010. The workshop was chaired by senior staff from the Directorate General for Family Planning (DGFP) with participation from implementing partners (representatives from MR NGOs and ICDDR, B), representatives of the Obstetrics and Gynaecological Society of
Bangladesh (OGSB), the Embassy of the Kingdom of the Netherlands, and United Nations Population Fund (UNFPA). Technical officers from WHO Country Office (WHO CO) of Bangladesh, the WHO Regional Office for the South-East Asia and the Department of Reproductive Health and Research from WHO headquarters and the national and international consultants for MTR also took part. The objectives of the workshop were to review the overall progress of the Project at mid-term of its implementation, discuss progress of individual projects under the Challenge Fund, share experiences for further coordination, encourage cross-partner interactions and learning, and solicit inputs of stakeholders for the MTR and its recommendations. The agenda and the list of participants of the workshop are presented in Annex C.

The field visits were carried out by the MTR team from 29 November 2010 to 8 December 2010. The implementing sites of five NGOs were selected for field visits namely, Family Planning Association of Bangladesh (FPAB) at Sylhet district, Marie Stopes Clinic Society (MSCS) at Moulvibazar district, Phulki at Dhaka district, Light House at Bogra district and Shushilan at Satkhira district. Observations of community group meetings and activities were conducted. Interviews were carried out with representatives of MR NGOs, community key stakeholders and gate-keepers, health staff providing MR services and beneficiaries. In addition, representatives of DGFP and the technical officer for maternal health (TO-MH) were also interviewed. The names of the key informants who provided information and were interviewed are listed in Annex D.

The information on technical and managerial aspects of project implementation was gathered using the assessment tools and synthesized qualitatively. The overall observations and recommendations for steering the implementation of ongoing activities and future directions of the MR Initiative, including suggestions for scaling-up, are presented in a consolidated report.

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8 Dr Katherine Ba-thike visited project sites of Marie Stopes, FBAB and Phulki from 28 November till 3 December 2010.
3. **Findings and recommendations**

The findings are grouped under the following four sections: Section I - Project governance by the DGFP; Section II - Project management by the WHO; Section III - Implementation of projects by the MR partners, and Section IV - Overall observations and recommendations for MR Initiative.

Section I: Project governance by DGFP

(1) **Stewardship and coordination**

The initial project document for the MR Initiative proposed to target six Upazillas (sub-districts) throughout Bangladesh. However, based on the geographical areas of work of the six selected MR NGOs, the clause was revised to increase the target sites beyond six Upazillas. At the request of DGFP, some of the MR NGOs extended their projects to hard-to-reach areas for vulnerable and underserved populations. This led to an increased coverage of varying geographical locations and populations in need.

DGFP chairs the Technical Advisory Committee (TAC) for MR Activities in Bangladesh to provide technical guidance, coordinate the implementation of the MR Project, suggest further improvement of implementation, and guide the technical adjustments based on the evidence of project review or evaluation. The MR Project served as a catalyst in a revitalization of the TAC with its first meeting held on 16 June 2008.

All IEC/BCC materials developed by NGOs were reviewed and approved by the Information, Evaluation and Monitoring cell of DGFP and subsequently by the IEC Technical Committee of the Ministry of Health before implementation.

As Chair of the Coordination Committee for MR Agencies in Bangladesh (CCMR,B) aiming at improving quality of MR services, DGFP held regular forums for all MR partners to share information and lessons learned, discuss challenges and identify areas for collaboration.
DGFP has discussed a process and plan for the development of national MR guidelines using TAC and CCMR, B platforms. A national consultant to develop these guidelines was identified in agreement with the two committees.

In place of a Steering Committee which was mentioned in the initial Project document, a Working Group was established in June 2008 comprising officials from DGFP, WHO and donor agencies active in the field of reproductive health. The Working Group was responsible to review the applications submitted in response to the call for proposals for the Challenge Fund in June 2008 and December 2009.

As the awareness of the communities was enhanced and demand for MR services increased, the directorate ensured that quality services were provided free in the public sector. In addition, the district hospitals had to manage more referrals from the public, private and NGO sectors. The increased utilization of MR services led to a parallel demand for contraceptives, which the DGFP is taking measures to address. Some NGOs reported temporary shortages of injectables and implants. This was addressed by DGFP in collaboration with the Deputy Director (Family Planning) (DDFP), and the supplies were replenished.

(2) Selection of grants

DGFP is a member of Working Group for selection of applicants for the Challenge Fund chaired by WHO. The presence of DGFP ensured that the linkages would be established and strengthened between the NGO partners and the public sectors in service delivery sites.

(3) Implementation

The role of DGFP is critical in securing provision of quality MR services, post-MR counselling and contraception, especially considering increased levels of community awareness and improved referrals from NGO clinics for complicated cases as a result of project activities. DGFP assisted smooth implementation of the MR NGOs’ activities in the field by communicating its support of these NGO’s projects to DDFP and service providers FWVs, FWAAs and HAs.
(4) Challenges and remedial measures

Changes in senior positions of the Directorate General for Family Planning and focal persons for the Project affected the momentum and implementation of activities as it required frequent orientation of new staff. While this situation led to considerable delays, it seems to have been resolved.

(5) Recommendations

DGFP plays an important role in supporting the implementation of the MR Initiative and promoting effective linkages between Deputy Director (Family Planning) (DDFP) and MR implementing partners locally. The DGFP’s role could be strengthened by:

1. Using the platform of this Initiative to establish/monitor quality improvement for safe MR services due to increasing community awareness and demand for MR services.

2. Formulating and implementing a plan for human resource development and skills training to address a shortage of FWVs/FWAs against the established posts in the public sector. This may be considered in collaboration with DGHS to optimize existing resources of the MOHFW.

3. Implementing a strategy for the use of standardized IEC/BCC materials in the public and private sectors.

4. Implementing joint DGFP-WHO field monitoring and supervision visits to project sites.

Section II: Project management by WHO

(1) Quality assurance of proposals

The identification of the proposals that would need to be further developed went through a review by a panel of international external experts and WHO staff from all levels of the Organization. This was followed by the first Working Group meeting to review and shortlist the proposals for consideration of funding. Feedback for amendments and clarification were provided to the potential candidates. Furthermore, WHO organized a workshop (30 November 2008–4 December 2008) to improve the
proposals and ensure coherence and quality. The workshop also provided an opportunity for the NGO candidates to exchange their ideas for interventions and implementation. The short-listed proposals were finalized through a process of revision, resubmission and re-approval. Contractual agreements between selected implementing partners and WHO were signed and the first disbursements were released by June 2009.

(2) Administrative arrangements

Staffing

The WHO CO in Bangladesh was supported by the staff of the Department of Reproductive Health and Research, WHO headquarters and the South-East Asia Regional office (SEARO) through different mechanisms. A professional staff from WHO-SEARO was based in the Country Office for four months (May-August 2008) to assist in start-up of the Project. During this period, the first “Call for Proposals” was announced at a launching ceremony held on 16 June 2008. In the meantime, for project management a Technical Officer for Maternal Health (TO-MH) was recruited in August 2008, initially on a temporary basis and later under a regular (long-term) position following the established WHO recruitment process.

Contractual arrangements

Selected applicants were contracted for implementation according to WHO established procedures under the financial and administrative supervision of the WHO Regional Office. The Contract Review Committee (CRC) of WHO SEARO reviewed and approved the selection process and budgeting of the projects. As the budget for the proposals exceeded the ceiling under the delegated authority of WHO CO, each project had to be cleared by WHO-SEARO. The applicants used the WHO country cost norms in their budget estimates. Procurement of office equipment for the projects and printing of IEC/ BCC materials were done by WHO as per established procurement procedures.

Progress report

The TO-MH reviews quarterly technical and financial progress reports submitted by the implementing partners with respect to quality, appropriateness, timeliness of the activities and utilization of funds with
reference to the agreement. All original bills and vouchers are reviewed as per WHO financial rules and norms.

(3) Technical support to MR Partners

The technical support has five phases: 1) proposal development by review, feedback and proposal strengthening workshop; 2) development of IEC/BCC materials; 3) project implementation and monitoring; 4) review of reports and activities and feedback for further improvements and modifications; and 5) development of a national guideline for MR services. The TO-MH conducted field visits and provided recommendations for improving the quality of project activities. In addition, TO-MH facilitated horizontal exchange of experiences between the MR NGOs. At the inception stage, WHO organized a workshop to guide the MR partners through WHO’s financial procedures and technical reporting. A framework for the national MR guidelines was jointly drafted by the DGFP, TAC members, WHO and a national consultant. As an input for the development of the national MR guidelines, WHO shared guidelines developed by WHO and its partners and those used in other countries in Asia, Europe and Africa with WHO support.

(4) Monitoring

The implementing partners (MR NGOs and ICDDR, B) are required to submit quarterly technical and financial reports to WHO CO. The TO-MH reviews the technical reports to verify whether the activities are implemented as per the agreed workplan with respect to timeliness and quality.

The financial reports are also reviewed by the TO-MH to match the workplan budget and for consistency with technical report. All the original bills and vouchers are verified by the Project Finance Assistant. Following the WHO in-office administrative and finance clearance, release of the next instalment of funding is executed.

Field monitoring visits to each project sites were planned as once every six month. At the time of review, the first visits had been carried out as planned, with the exception of a site visit to Satkhira, where Shushilan was implementing its project, due to cyclone Aila (25 May 2009). All the project sites have been visited as planned in the second year of the projects. TO-MH was accompanied by a central-level staff of the respective NGOs to the sites. Detailed monitoring of all the workplan activities was
conducted. Meetings for sensitization and community mobilization were held with local government, NGO partners and co-partners, formal and informal service providers and other stakeholders. Visits also included observation of community meetings, training of target groups, and service provision by the public sector and NGOs, following which feedback was provided to the NGO partners for changes and improvement. Any suggested actions were followed-up and reported.

(5) Dissemination and sharing of experiences

The experiences of the MR Project shared at the regional follow-up workshop of the International Federation of Gynaecology and Obstetrics (FIGO) in Dhaka, July 2009 generated interest from the participants. The Global Maternal Health Conference, held in New Delhi in September 2010, was another experience-sharing opportunity, where the MR Project in Bangladesh was discussed by the WHO panel.

The project proposals were shared with other health partners in the country, e.g. the World Bank and UNFPA, who are the members of the Working Group. An additional advantage of sharing the information on the Initiative was avoiding the duplication of activities and generating support for MR implementing partners. The Obstetric Gynaecologists Society of Bangladesh (OGSB), the leading professional society in Bangladesh, was also informed of the MR Project and its members were involved through different stages of the Initiative. The MR Project activities contributed to and complemented the workplan of the OGSB.

(6) Coordination and communication with the Embassy of the Kingdom of the Netherlands

Communication with the Embassy of the Kingdom of the Netherlands is carried out on a formal and informal basis. WHO CO submitted the annual technical and financial reports to the embassy for the periods January 2008 December 2008 and January 2009 December 2009.

Embassy staff participated as observers in the Working Group meetings on selection of proposals, the proposal strengthening workshop, and a field monitoring visit. Positive cooperation and partnership were established between WHO and the embassy staff at all levels that helps facilitate the implementation of the Project.
(7) **Coordination and communication with NGO implementing agencies**

The WHO CO regularly communicated with implementing agencies to provide technical support to the projects for improving on the project documents, the quality of implementation of activities and strategies for awareness creation, development of IEC/BCC, and orientation workshops. WHO CO also coordinated the sharing of experiences among MR NGOs and recommended lesson learned for NGO implementing agencies.

(8) **Challenges and remedial measures**

A Gantt chart with details of the planned activities and the timeframe are integrated into the original MR Project proposal. However, the Project document did not take into consideration the time required for the set up of the project and the preliminary activities. Lead time was not considered for the selection of dedicated project staff, preparation of the “Call for Proposals”, announcement of the call itself, and the time required for the development and submission of concept notes and full proposals by the applicants, as well as review, strengthening and selection of the proposals. As a result there have been delays in implementation and utilization of the funds.

The standard operating procedures are different among UN agencies, and WHO does not allow a national execution, in other words, direct management of funds by the Government of the 10% of the Challenge Fund allocated under Component 4, “Strengthening Policy Response”. DGFP perceived this as bureaucratic and affecting the autonomy in implementation.

This is one of the first projects where WHO is executing and implementing a substantially funded project directly with many NGOs over a wide geographic area within the tight time-frame. This required substantial commitment and time from a single WHO staff.

(9) **Recommendations**

- The WHO administrative platform and rigorous review mechanisms required a considerable lead time for the review of documentation and release of funds by WHO to MR partners. A managing agency should take into account the administrative
processes and corresponding lead times in the future to avoid delays in the start-up and implementation of the projects and timely utilization of funds.

- In certain circumstances, rigid budget planning may jeopardize project implementation and management. Built-in contingency or any other mechanism should be accommodated in the planned Project budget to address legitimate unforeseen expenditures.
- On-going and future activities under each component should be reviewed to meet the revised budget and plan of action.
- Site visits by WHO proved to be useful and should be continued on a regular basis to provide technical support and capacity building.

Section III: Implementation of Projects by MR partners

WHO announced two calls for proposals to be funded by the Challenge Fund for implementation of MR activities as indicated under the four project components, namely: (i) Scaling up delivery of quality MR service; (ii) enhancing rights-based demand generation for safe MR services; (iii) improving knowledge and evidence on sexual reproductive health and right issues; and (iv) strengthening the policy responses. The deadline of the first call was 22 July 2008 and the Working Group met to review the proposals on 8 September 2008. The deadline of the second call was 30 November 2009 and the Working Group meeting was conducted on 21 December 2009.

NGOs, professional organizations, and research and academic institutions that met the eligibility criteria were urged to apply for the grant. The five assessment criteria for grant approval were grouped as follows: financial and operational capacity of the applicant; relevance of the

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9 Eligibility criteria, as described in the call for proposals: NGO Affairs Bureau and/or Social Welfare Department and/or be a government or business undertaking able to receive foreign funds; proven and documented track record of working successfully on menstrual regulation; audited average annual turnover, over the last 3 years, of at least US$ 50,000; experience of carrying direct responsibility for the preparation and management of the project with partners.
proposal to national needs, local context and the objectives of the Initiative; appropriate methodology; and sustainability, budget and cost-effectiveness.

A list of selected proposals, implementing partners and target geographical sites are shown in Table 1 and Figure 2, respectively. The Marie Stopes Clinic Society proposal on “Public-Private Partnership in Improving Safe MR Services” targeting the Narayanganj district of the Dhaka division was selected under the first call, and subsequently a similar proposal for the implementation in Sylhet, Chittagong and Dhaka district of Dhaka division was submitted and funded under the second call.

The Annex E at the end of the report captures progress against selected projects. The next sections of the report provide a descriptive review of the implementation of the projects funded under the Challenge Fund.
**Table 1: Overview of selected NGO MR projects for the MR Initiative**

<table>
<thead>
<tr>
<th>Projects</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First call: Implementation</strong></td>
<td></td>
<td></td>
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<tr>
<td>Light House from 01 June 2009 to 31 May 2011</td>
<td>Improving access to menstrual regulation services for marginalized and underserved populations in Bogra and Rajshahi</td>
<td>Bogra &amp; Rajshahi</td>
</tr>
<tr>
<td>Shushilan from 01 June 2009 to 31 May 2011</td>
<td>Demand generation for safe MR services in rural Bangladesh through a rights-based approach – in districts of Satkhira, Upazila: Kaliganj, Shyamnagar and Debhata in Bangladesh</td>
<td>Satkhira – Khulna</td>
</tr>
<tr>
<td>Marie Stopes Clinic Society from 01 June 2009 to 30 April 2011</td>
<td>Public-private partnership in improving Safe MR services in Narayanganj district of Dhaka division, Bangladesh</td>
<td>Narayanganj - Dhaka</td>
</tr>
<tr>
<td><strong>Second call: Implementation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phulki from 01 July 2010 to 31 December 2011</td>
<td>Safe maternal health for awareness creation for safe and quality MR services in garment factory employees in Dhaka and Chittagong districts</td>
<td>Garment Factories-17 in Dhaka, 1 in Chittagong</td>
</tr>
<tr>
<td>Family Planning Association of Bangladesh (FPAB) from 15 April 2010 to 15 October 2011</td>
<td>“Access to quality MR services as women’s right” (AMRWR) by Family Planning Association of Bangladesh</td>
<td>Barisal, Chittagong, Sylhet, Magura in Jessore in Khulna division, Jhalakati in Barisal division and Netrokona in Mymensingh in Dhaka division</td>
</tr>
<tr>
<td>Marie Stopes Clinic Society from 15 April 2010 to 15 September 2011</td>
<td>Public-private partnership in improving safe MR services in Sylhet, Chittagong and Dhaka district of Dhaka divisions, Bangladesh</td>
<td>Feni district, Chittagong division; Moulvibazar district, Sylhet division; and Sherpur district, Dhaka division</td>
</tr>
<tr>
<td>Bangladesh Association for Prevention of Septic Abortion (BAPSA) from 01 July 2010 to 31 December 2011</td>
<td>Demand generation for safe MR services and reduction of unsafe MR in rural areas of Bhola district under Barisal division, Bangladesh</td>
<td>Bhola district of Barisal division</td>
</tr>
<tr>
<td>ICDDR,B Research Proposal from 01 March 2010 to 31 July 2011</td>
<td>Sociocultural aspects and women’s perceptions on menstrual regulation and menstrual regulation services in Bangladesh</td>
<td>Research study in slum dwellers - Komolapur, Dhaka; Tribal population - Mirersharai, Chittagong; Coastal people - Shyamnagar, Kaligonj, Shatkhira; and perceived conservative population - Kanaighat, Sylhet</td>
</tr>
</tbody>
</table>
Figure 2: Geographical sites of selected NGO projects

- ICDDR,B
- Maries Stopes Clinic Society
- Phulki
- Light House
- Family Planning Association
- Shushilan
- BAPSA
1. **Light House: Improving access to menstrual regulation services for marginalized and underserved populations in Bogra and Rajshahi**

1.1 **Short description of the project**

The Light House partners with Khulna Mukti Sheba Sangstha (KMSS) plan to provide sexual reproductive health (SRH) information and facilitate access to quality MR and contraceptive services for the most vulnerable and marginalized population groups: female sex workers, men having sex with men (MSM), female drug users, and populations in slums and rural areas of Bogra and Rajshahi. The total duration of the project is 24 months from June 2009 to May 2011 with a budget of US$ 172 676.

The two main activities included outreach and clinical services. Outreach consisted of distribution of IEC/BCC materials with sessions and advocacy meetings (group and individual one-to-one sessions, sessions with eligible couples) for sensitization and awareness liaising about family planning, MR, sexual and reproductive health and rights and violence against women. Clinical activities are provided by KMSS; these include pre- and post-MR counselling, client screening and physical examination, MR services (including provision of antibiotics and contraceptives), post-MR follow-up, hotline services and referrals for MR complications. KMSS provides free services to the project beneficiaries (the cost of services is subsidized by the project).

1.2 **Progress/status of the implementation**

All project activities of service delivery and rights-based demand generation for safe MR services were implemented according to the workplan. Recruitment of staff and procurement of supplies and equipment were carried out. Regular meetings were conducted with project staff, community volunteers, local government, allied NGOs and KMSS partners. In addition, training of staff on sexual and reproductive health and rights and training of counsellors on MR by the Marie Stopes Clinic Society were carried out. Arrangement of referral service systems between KMSS and public health services were put in place. A baseline survey on knowledge, attitudes and practices (KAP) was conducted at the beginning of the project.
Community activities (conducting community sensitization meetings with the target population including female sex workers, intravenous drug user’s wives and MSM’s wives) were carried out. Videos and films on reproductive/maternal health were collected. Live cultural shows were put on to increase awareness of MR. IEC/BCC materials were disseminated to communities and hotline services set up. A memorandum of understanding (MoU) was signed between Light House and KMSS, arranging for KMSS to provide MR clinical services for the project.

The KAP survey conducted at the inception of the project provided information on the knowledge and attitudes on access to MR, SRH, right-based issues and contraceptive use among the target population. This survey highlighted the limited utilization of safe MR services in formal health facilities due to lack of information about MR services, inability to afford safe MR services due to limited financial resources, and the social stigma attached to MR. The negative attitude of some health providers was also a deterrent to seeking services.

Light House noted an increased knowledge among the target population, leading to improved and early health-seeking behaviour for safer MR. This resulted in a reduced number of MR cases rejected by health clinics due to late reporting for MR services.

1.3 Facilitating factors

Light House has a systematic organization and well-defined activities to reach different categories of sex workers, i.e. hotel-based, facility-based and street sex workers. Light House has a drop-in centre for sex workers funded by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as part of Light House’s HIV/AIDS project. This drop-in centre offers one-on-one services such as counselling, laboratory tests and treatment for sexually transmitted infections (STIs), and voluntary counselling and testing (VCT). Under the project, Light House introduced group counselling and awareness creation for safe and high-quality MR services. Peer educators selected from among sex workers were trained to disseminate key MR messages. The Light House drop-in centre serves as the contact point for all the different categories of female sex workers to provide information on SRH and MR. A similar centre exists for MSMs, which includes a 24-hour hotline service.
Light House visited the Marie Stopes project site at Narayanganj to further strengthen their field activities. This is a good example of cross-organizational leaning among the MR NGOs under this Initiative.

1.4 Challenges

Beneficiaries

The challenges in the implementation of the project are related to the mobility of the beneficiaries, their low literacy and limited knowledge of health issues. Although it is possible to contact MSMs and sex workers by mobile phone, it becomes difficult to communicate with them if they move out of the project area.

To overcome low literacy, community mobilizers employed diverse approaches to channel the information on SRH and MR to the target audience. This included face-to-face individual sessions, group talks using flipcharts with pictorial depictions of messages, and information-sharing through the literate members of the community by supplying them with leaflets and written materials.

The staff found that changing opinions of elderly women and men was particularly challenging due to their conservative outlook and religious beliefs. However, they formed a small segment of the target population and allowing them to observe group sessions changed their perceptions.

Staffing

Demanding travel to various project sites, including remote areas, made recruitment and motivation of project staff difficult. In addition, staff turnover was high as the salary package was not competitive with that of other organizations.

Availability of FP and MR services through the public sector

The quality of FP and MR services is determined by multiple factors including the availability of supplies and the clinical and interpersonal skills of service providers. Contraceptive commodities are centrally procured and
supplied by DGFP to both public and private facilities. The stock-outs of injectables and implants were reported over brief periods. In Bogra, the Deputy Director (Family Planning) explained to the review team members that the stock-outs were temporary, due to delays in procurement by UNFPA and the World Bank, and that the contraceptive supplies had been replenished and a regular supply had been restored.

The DGFP criterion for the distribution of MR kits is based on the number of reported cases. Underreporting of MR service utilization, from both the public and private sector, led to a limited number of kits being provided. The awareness-raising activities of the project have led to a shift in women seeking MR services from the informal to the formal sector, thereby creating an increase in the demand for MR kits. However, the supply has not met the increased demand. As a result, re-use of MR kits was observed by the MTR Team. This raises concerns about the risks of infection, complications, and morbidities arising from the use of improperly sterilized MR cannulae.

1.5 Findings and recommendations

Technical monitoring by WHO involved visits and regular communication with both Light House and KMSS. Technical supervision and guidance by WHO CO were appreciated by the NGOs and helped in improving the technical content and implementation of activities, for example the quality of SRH/MR messages and data collection for monitoring of activities.

Initially, all community mobilizers who provided messages to the community were women. The strategy of introducing male staff to communicate with the men’s group led to improved receptiveness to the SRH messages by men, who are the decision-makers in the family. The recruitment of volunteers further optimized the promotion of SRH and MR messages by reaching out to wider groups.

While gradual improvements in project activities took place following WHO technical feedback, some recommendations have yet to be adequately addressed, such as improving facilitation skills of the community mobilizers, structuring the IEC/BCC target groups and arrangement of group sessions. These could be addressed through training of community mobilizers and technical supervision.
**Recommendation:** Community mobilizers should be encouraged to use interactive methods to be able to engage the audience and increase participation during group sessions. Close monitoring and technical supervision of the project implementation should be continued by Light House. To strengthen training and technical supervision, Light House may need to identify an experienced staff to followup on this. This is especially important should the project be continued or expanded.

Figure 3: **Group sessions including women and a community leader with a community mobilizer.**

The IEC/BCC materials for the project were developed in collaboration with MSCS and Shushilan to deliver coherent messages, and the materials were approved by DGFP. It was reported that due to unexpected delays in development, approval and printing of these IEC/BCC materials, they were not available in initial 3 months of the projects. However, sufficient copies of IEC/BCC materials were available for distribution during the MTR visit.

**Recommendation:** For future activities, the time required for development, testing, clearance, printing and dissemination of IEC materials needs to be considered prior to the start of project implementation.

MR services in the project are provided by KMSS along with pre- and post-MR and FP counselling by the counsellors trained from MSCS. Light House and KMSS developed referral slips, which are distributed to the women by the community mobilizers during the awareness-creation activities. The slip contains three parts: one part is kept with the community
mobilizer, one part is kept by the women, and the third part is retained at the KMSS clinic in exchange for MR services should the woman opt for it. The referral slips contain basic information on women and are a helpful tool for referrals and in project monitoring to gather information on women who received information and services on MR at a subsidized cost. While these slips are a useful mechanism to determine the number of women receiving MR services after the IEC/BCC activities of the project, the possibility of use of MR services outside the KMSS clinic were not accounted for.

Recommendation: In addition to using referral slips for case identification under the project, the slips can also be used for monthly monitoring of MR service utilization in any public, private or NGO clinic providing services under the project. The referral slips could serve as a direct monitoring tool to estimate the number of clients who accessed safe MR and FP services following the project’s awareness-raising activities. Moreover, these monitoring mechanisms would give a platform for enhancing the information base for SRH, MR and FP in public and private clinics of the project areas.
2. **Shushilan: Demand generation for safe MR services in rural Bangladesh through a rights-based approach in district of Satkhira, Upazillas: Kaliganj, Shyamnagar and Debhata in Bangladesh**

### 2.1 Short description of the project

Shushilan used an “awareness, action and advocacy” model and a rights-based approach. It focused on raising awareness related to reproductive health, women’s rights and fertility regulation-related issues in the community, in order to create demand for FP and other RH services in the catchment population. Community awareness is generated through trained *Shwadhikar* (a social advocacy group of women) members using IEC/BCC materials and picture song shows on FP, MR, sexual reproductive health rights (SRHR) and violence against women (VAW). The *Shwadhikar* is experienced in working in the community on development issues. The project messages of "right place, right person and right time" for MR were communicated primarily by this group.

To meet the demand for services generated by the increased awareness, Shushilan worked in close collaboration with the local-level DGFP providers and managers to ensure availability of these services.

To ensure an alternative source of such services, Shushilan also partnered with Nalta Community Hospital to improve its capacity to address issues related to FP and RH (including safe MR services). Advocacy by Shushilan focused on developing the capacity of the providers to understand the issues related to clients’ rights and how to act accordingly.

The project sites are Kaliganj, Debhata and Shyamnagar Upazillas of Satkhira district, which is the most remote and poorest district of Bangladesh. The project’s duration is 24 months, from June 2009 to May 2011, with a budget of US$ 146 538.

### 2.2 Progress/status of the implementation

All the programme activities have been conducted as planned. These included: (i) advocacy meetings with service providers, managers, local DDFP and social advocacy group members, i.e. Shushamaj (leaders) group; (ii) orientation and training of Union Health Educators (29 community
women recruited by Shushilan) as trainers, and (iii) training of selected Shwadhikar group members as local facilitators. Orientation and advocacy meetings have been conducted with the formal sector, both public and private of the Shyamnagar, Debdatta and Kaliganj Upazillas. The issues of reproductive health rights, maternal and reproductive health, safe MR services, FP methods, negative impact of early marriage and VAW were covered. Courtyard meetings were held with young newly married couples, mothers and mothers-in-law. A memorandum of understanding with Nalta Hospital was signed for clinical MR services including pre- and post-MR counselling.

An initial baseline survey was conducted at the inception of the project to gather information on knowledge, attitudes and practices related to MR, SRH, right-based issues and contraceptive use. A lack of knowledge on safe MR and FP services and right of access to safe MR and other reproductive health services was noted based on survey findings.

2.3 Facilitating factors

Shushilan’s 19-year effort to improve quality of life among the poorest segments of the community using the rights-based approach has provided a solid platform for the implementation of this project. The use of existing social leader groups such as Shwadhikar (women) groups, Shushamaj (leaders) groups and Shuvoshakti (youth) group is very effective for dissemination of messages to various segments of the community.

Close cooperation between Shushilan and the local DDFP management is maintained through the Project Management Committee. Shushilan and Nalta Hospital are partners in implementing this project, whereby the Nalta Hospital provides safe MR services at a subsidized rate to the women referred by the Shushilan project.

2.4 Challenges

The occurrence of cyclone Aila (May 2009) in the project area delayed implementation by two months as all efforts were steered towards emergency relief operations. Since then, project implementation has picked up and was subsequently adjusted in line with the planned timeline for 2010.
The *Shwadhikar* group members are rural housewives with limited education, and more efforts are needed to train them with necessary skills for dissemination of messages.

Religious and cultural beliefs are major barriers for effective communication of messages. Shushilan’s project interventions, involving madrasa (religious schools) and school-teachers, are directed to address these barriers. As elderly people, women in particular, play an important role in families and communities, the picture drama and performances carried out by the project were additional opportunities to specifically address concerns and misconceptions of elderly women on SRH and MR.

Due to the remoteness of the area, it is difficult to employ and retain skilled staff for project monitoring. Therefore, provision of technical assistance from the WHO CO has been important for developing project monitoring tools and mechanisms.

The pay scale for Shushilan’s staff was in line with government rates as required by WHO standard practices. But while public wages have increased over the last year, project staff remuneration was not revised to the current rates as the WHO system does not have contingency funds within the agreed project budget to do this.

### 2.5 Findings and recommendations

Shushilan was able to develop strong community mobilization on such issues as prevention of early marriage and adolescent pregnancy, violence against women and demand for quality MR and FP services. Awareness creation and demand generation activities have been delivered using the platform of the two powerful groups of Shushilan: 1) *Shwadhikar* (Women’s Organization) – a group of women selected from the community; and 2) *Shushamaj* (Citizen’s Forum) – a group of community leaders (both men and women) in addition to formal Union Health Educators. Besides the core project strategies, Shushilan engaged members of *Shuvoshakti* (Youth Organization), a group of young boys and girls, to increase awareness about the risks of early marriage and adolescent pregnancy. In addition to these, Shushilan’s educators provide health-related education sessions on menstruation and personal hygiene to the girls in madrasa.
Courtyard meetings for community women’s groups were jointly conducted by the trained members of Shwadhikar and a Family Welfare Assistant (FWA). Besides reinforcing messages, the FWA offers services and contraceptives of women’s choice immediately after the meeting, as well as ensuring reporting and referrals to public health facilities in case of any suspected SRH problems. The courtyard meetings hosted active discussions by all participants. Facilitators used the flipcharts for conducting their sessions and distribute leaflets.

**Recommendation:** The rights-based approach to generate demand for quality MR services, contraception and other RH services used by Shushilan is built on the principle “for community, by community”. The strong partnership of Shushilan, the local government (DDFG) and the community should be regarded as a model for future implementation.

**Figure 5:** Group meetings a) courtyard meeting by a Shwadhikar member and a Female Welfare Assistant; b) meeting with Shushamaj group; c) meeting with Shuvoshakti group; and d) meeting with madrasa students.
The project developed picture dramas and song performances to communicate key MR messages to the community. The right to reproductive health and access to FP and MR services has been expressed by pictures and songs in lively performances. The picture dramas and song performances have been very popular and well-received by the communities, and were of high quality in terms of content of messages and artistic presentation, which the MTR team was able to witness during the site visit.

**Recommendation:** WHO, in collaboration with DGFP, may consider producing video materials of the Shushilan’s drama shows to share with other MR partners and to implement as part of the national IEC/BCC activities.

*Figure 6: Picture song and drama shows*

Close cooperation and regular engagement of Shushilan with the local government and rights-based demand for services by the communities resulted in improved access, availability and utilization of contraceptives services and supplies for the community through: (a) the FWAs (oral pills, injectables for continued users and male condoms) and (b) the public clinics (temporary and permanent methods) and (c) provision of safe MR services by FWVs on a no-cost basis. DDFP recognizes and appreciates the fact that the Executive Committee members and the health educators of Shushilan are complementing the work of DDFP by educating women and communities on SRH issues. This is an example of positive partnership between Shushilan and DDFP. FWAs are part of the community and the majority are current members of the Shushilan’s General Committee directly representing the community and their needs.
Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh

Shushilan has a reputation for creating opportunities and enabling the most socially disadvantaged communities to achieve sustainable development, livelihoods, and access to social services, including health services. Greater awareness and community demand for safe services has forced the closure of two illegal MR service centres (Box 1).

**Box 1:** Local project manager about the closure of the illegal MR service center in Shamnagar “This is a big success... There was a [illegal] clinic providing MR services in front of the Shamnagar public health complex... service quality was poor and women suffered from complications... Due to the pressure of the community people and the local elected leaders the clinic was closed. So it is a big success of this project”.

Similarly, the strong pressure generated through the community groups, especially youth groups, led to preventing 9 cases\(^\text{10}\) of early marriages (below age of 18); 19 cases\(^\text{11}\) of violence against women were taken up for legal action with the support of the elected government.

The positive effect of the project activities in the three selected Upazillas has raised the demand of the remaining seven Upazillas and has led to the formation of district committees. This was expressed to the MTR team by various groups.

**Recommendation:** The activities of the Shushilan project would be a good model for consideration for future scale-up of the MR Project.

Within the framework of the MoU with Shushilan, the Nalta Hospital provides MR services, including pre- and post-MR counselling at subsidized rates. However, for post-MR FP services women are referred to the public sector as these services are not available in the Nalta Hospital. Thus, while the number of MR clients under the Shushilan project is well recorded, it is difficult to follow-up on the number of women receiving post-MR contraception.

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\(^{10}\) Project Progress Report.

\(^{11}\) From interview of project staff and community workers during the MTR visit.
The personnel responsible for MR at Nalta Hospital said that they often face a shortage of trained MR service-providers for the provision of services at their hospital.

**Recommendations:** The possibilities for offering a “one-stop” MR and FP service to women at the Nalta Hospital should be considered to increase the utilization of post-MR contraception and contribute to achieving the objectives of the MR Initiative.

A monitoring mechanism to track service provision, post-MR contraception and other results of awareness-increasing activities is needed. The format of the referral slips developed by Light House could be used as an example to collect and analyse information on numbers of women utilizing MR and post-MR FP services in both public and private health facilities as a result of demand-generation activities of the project.  

The issue of shortage of skilled MR service-providers needs to be addressed at the policy level to ensure availability and quality of services both in the public and private sector.

3. **Marie Stopes Clinic Society (MSCS): public-private partnership in improving safe MR services in Narayanganj district of Dhaka division, Moulvibazar district of Sylhet division, Feni district of Chittagong division and Sherpur district of Dhaka division, Bangladesh**

3.1 **Short description of the project**

The Marie Stopes Clinic Society (MSCS) is an NGO that provides a wide range of SRH services including MR services. Under the first call, the project site was at Narayanganj in Dhaka Division. The population of Narayanganj

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12 The Light House referral slips contain three parts: the community mobilizer distributes two parts of the same slip to women during awareness-creation activities and leaves the remaining part for the project records. The women are asked to hand over the slip to the health provider when they come for services (subsidized services at the project partner clinic, in this case). Both sides of the slip are filled in the basic data of a recipient of services; one part of the slip is kept with the clinic and the other is given back to the client.
is a mixture of different socioeconomic groups including industrial workers who are believed to have a relatively large number of menstrual regulations carried out. The project is for 23 months from June 2009 to April 2011, with a budget of US$ 193,272.

Moulvibazar, Feni and Sherpur were selected as implementation areas under the second call. These locations were selected based on request by DGFP, as these areas are hard to reach with poor and underserved populations. The total duration of this project (in the three locations) is 18 months from April 2010 to September 2011 with a total budget of US$ 557,920.

The objectives, strategies, activities and outputs of the MSCS programmes under the two calls are similar. The main objective is to prevent unwanted pregnancies and promote utilization of safe and quality MR services in public, NGO and private service delivery facilities. The issue of VAW was incorporated into the implementation plan following the demand from the communities in Narayanganj after six months of implementation. The Female Community Support Groups (FCSGs), microcredit NGO field workers, locally elected leaders/representatives, female teachers, key decision-makers who are men, health and FP field workers and NGO field workers were sensitized and oriented to deliver messages to the community to increase awareness about prevention of unwanted pregnancy and unsafe MR services. In addition, the providers were oriented on the rights-based approach and trained on technical and non-technical standards of MR services and guidelines of infection prevention. A referral system for management of complicated MR cases was set up from the MSCS clinics to the government facilities.

3.2 Progress/status of the implementation

The project activities to raise community awareness with orientation sessions, meetings and sensitization activities among various target groups have been conducted as planned. The MTR team was able to meet the MSCS Project Committee, FCSG members, microcredit NGO workers, managers/supervisors, elected women representatives, women school/college teachers, key decision-makers who are men, formal and informal leaders, gatekeepers to health, and FP field workers. The Upazila Members and Upazila Chairman also participated and supported the community activities.
The public private partnership (PPP) in improving safe MR services was emphasized through the NGO collaboration with DGFP and DGHS. The rights of women for access to SRH, MR and FP services were emphasized to the service providers through a right-based approach (Box 2). Service providers were also trained for infection prevention and oriented with technical and non technical guidelines to improve quality of services and an effective referral system as planned.

Box 2: Project staff MSCS, Moulvibazar: “The project is an opportunity to strengthen the rights-based approach for health services. In addition to technical issues such as infection prevention, orientation on clinical and non-clinical guidelines and referral mechanisms, the rights-based approach is emphasized during training for service providers and community support groups.”

A KAP survey, conducted at the inception of the project, provided baseline information on knowledge, attitude and practices on FP and MR services of community female and male respondents. There was a variation of knowledge of the community on FP and safe MR services in the four project areas. A lack of knowledge about safe MR, negative attitudes regarding MR, yet good knowledge on FP methods were all reported in survey.

3.3 Facilitating factors

MSCS has a wealth of experience in the field of sexual reproductive health in both community and clinical activities. MSCS clinics are well established and have trained staff for MR services with established standards and protocols. MSCS has led the other MR NGO partners in the development of IEC/BCC materials. Other NGOs have observed activities conducted by MSCS: a good example of cross-organizational learning leading to improvement in the quality of implementation.

The community awareness-raising strategy employed is a multi-pronged approach involving different persons in the community: FCGS, microcredit NGO field workers, female locally elected leaders, female teachers, key decision makers who are men, health and DGFP and NGO
field workers. This strategy is also sustainable and community driven by volunteers with no monetary incentive involved. Good retention of the trained and experienced FCSG has been the key to successful and effective dissemination of key messages.

3.4 Challenges

As the literacy rate among community women in the project area is low, group discussions or meetings are held to convey key messages. Alternatively, printed IEC/BCC materials are also read by their children and other literate community members.

MSCS successfully convinced and obtained the concurrence and cooperation of the principals and female teachers of the schools and colleges as well as approvals from the district-level education department to implement activities focusing on school-girls and female college students.

A shortage of contraceptive injectables and implants from the public sector was reported for a brief period. Such instances could hamper FP promotion, resulting in an increase in unwanted pregnancies.

3.5 Findings and Recommendations

Uniform and consistent messages on prevention of unwanted pregnancies by using FP methods, safe MR, post-MR contraception, avoiding early marriage, delaying the age of first pregnancy and prevention of violence against women were consistently conveyed during the awareness-raising sessions. FCSG, key decision-makers, NGOs field workers and school-teachers volunteer to participate in this project. The key decision-makers targeted include male and female formal leaders, elected female workers, religious leaders and social leaders in the community.
The teachers carried out the sensitization sessions as part of their extra curricular activities. They disseminate the messages in an informal way to a small group in the girls’ common room. Therefore, the coverage of the girl students would not be as extensive as in an exclusively girls’ school, nor would it be in such a systematic manner. During the implementation of the project, MSCS responded to the request from male teachers to include them in the orientation meetings. Therefore, several male teachers participated in the ongoing training.

**Recommendation:** The modality whereby female biology teachers incorporated SRH and MR information in their lectures in girls’ schools and colleges worked well. However, the dissemination of these messages in the co educational schools proved more of a challenge. The MSCS should hold further discussions with the teachers from these schools to strengthen information dissemination. Although the trained male teachers are interested to disseminate SRH messages to male students, it would require a different approach and additional IEC/BCC materials, which may not be possible within the scope of the current project.

MSCS works closely with local government staff and public facilities, i.e. FWVs, FWA and HA for providing FP and MR services in public sectors at the Upazila Health Complex and Upazila Health Family Planning service centres (Box 3). The acting DDFP explained that a temporary shortage of contraception was due to delays in procurement. However, it is now resolved and the contraceptives have been distributed to community clinic levels without problems. He also said that the response to the IEC/BCC approaches is positive and that community awareness continues to increase.
Box 3: DDFP Officer, Moulvibazar: “MSCS works well with local government within this project through FWVs and establishing informal referral system to public hospitals”.

Development of the educational materials was done jointly with Light House and Shushilan to deliver uniform messages. Messages relating to the rights-based approach for RH services, which had been approved by DGFP, were incorporated in the materials. Field testing of the materials was done by all three NGOs and slight modifications were made before printing. IEC/BCC materials include a brochure on "right time, right place and right person" for safe MR services, a poster on safe MR “to do” and “do not do” and two leaflets: one on the right to access to safe MR services and another on prevention of VAW (Annex F).

MSCS has extensive experience in conducting interactive training to ensure community participation during the sensitization/awareness creation sessions. MSCS was requested to facilitate the training of community volunteers and service providers in other NGO projects, especially for the projects selected in the second call.

Recommendation: MR NGOs would benefit from training of project staff on interactive and participatory approaches, and therefore various modalities for training should be considered by DGFP and other implementing partners. Among other options, the capacity of MSCS and their experience in training should be considered and explored for training needs in MR.

A monitoring system of activities and outputs by regular follow-up, close supervision, feedback and motivation was in place.
4. **Phulki: Safe maternal health for awareness creation for safe and quality MR services in garment factory employees in Dhaka and Chittagong districts**

4.1 **Short description of the project**

The garment workers are an underserved population who have limited access to FP and MR services. Phulki considered the importance of this issue among the workers in garment factories; increasing awareness on sexual reproductive health rights (SRHR), FP, MR and VAW is critical for this population. The total duration of the project implemented by Phulki is 18 months, from February 2010 to July 2011, with a budget of US$ 84 600. The project started in July 2010.

The main objective of the project is to prevent unwanted pregnancies and enhance rights-based demand for safe MR services among garment workers in 17 garment factories in Dhaka and 1 in Chittagong Division. The strategies are building awareness among garment factory owners, training master groups and peer educator groups to disseminate the key messages to the factory workers using IEC/BCC materials to lead to desired behavioural change (i.e. prevention of unwanted pregnancy). As Phulki does not have the capacity to provide MR services, the project liaises with the local private clinics and hospitals for services.

4.2 **Progress/status of implementation**

The participating factory management took part in an initial orientation. Subsequent meetings are planned with the Bangladesh Knitwear Manufacture and Exporters Association (BKMEA) and Bangladesh Garments Manufacture and Exporters Association (BGMEA) on the programme activities to orient and review the progress of implementation.

Phulki staff identified and trained master trainers and peer educators among the factory staff, who in turn disseminate key messages on SRH, FP, MR, delaying early marriage and first pregnancy and prevention of violence against women. Those seeking MR/FP services are referred to the government or NGO service provider of their choice.
4.3 Facilitating factors

Phulki has a strong relationship with the selected garment factories and has been a pioneer in introducing day care centres for women employees (Box 4). This has provided a convenient entry point for the MR Project. During the field visit the MTR team met with senior managers and welfare officers of the garment factories, who were very supportive of the project.

Box 4: Senior Manager, Finery garments (project site of Phulki):
“We had invited Phulki to set up day care centres for mothers a few years ago and we found it to be beneficial for the mothers as well as the factory management. Now Phulki is introducing messages on reproductive health and MR through the day care centres and we expect it will have the same positive results”.

4.4 Challenges

Out of 18 factories initially selected, four garment factories opted out due to various factors and were replaced. The implementation of workplan activities slowed down during the Ramadan and Eid festivals as messages on SRH were considered inappropriate to discuss during that period. Phulki requested technical assistance from MSCS for training on basic RH and communication skills and techniques for conveying the key messages, as well as training of the peer groups.

4.5 Findings and recommendations

Phulki developed a participatory approach in the selection of master trainers and peer educators. They identified 10 persons from each factory: four from the master trainer group and six from the peer educator group. The master trainers comprised of the factory welfare officer, the responsible person in-charge of the day care centre, a manager and a supervisor, of whom at least one was male. The peer educators were identified by the mothers who used the day care centre. They selected both mothers and unmarried women who had good communication skills and were willing to give some of their time for these activities. At least two members of these peer educator groups were men.
Considering that factory workers are a mobile population group, Phulki includes additional factory workers or managers in the training to ensure that there is a “second-line” group of trainers and peer educators.

Refresher training is planned to be conducted in five months after the orientation training. Furthermore, a monthly reporting and review meeting of activities and coverage is held where experiences of peer educators are shared and the issues raised by the workers are discussed.

Due to requests from factory managers, more master trainers and peer educators were trained to meet the needs of factory workers. Optimizing support of the BGMEA and BKMEA for the MR and FP activities is a crucial prerequisite for improving sexual and reproductive health of the specific target population groups. It was felt that informing and obtaining support from BGMEA and BKMEA should have been carried out in the planning phase.

**Recommendation:** Regular orientation and advocacy events for BKMEA and BGMEA are important and these should be ensured early in the project inception phase.

A baseline survey on knowledge, attitude and practices of garment factory workers on reproductive health, family planning and MR services conducted at the start of the project provided useful information. Approximately half of the respondents knew about reproductive health, family planning and MR services; however, there was variation in the depth of their knowledge.
5. **Family Planning Association of Bangladesh (FPAB): access to quality MR services as a women's right**

5.1 **Short description of the project**

The Family Planning Association of Bangladesh (FPAB) is an NGO providing a wide range of SRH services, including MR services operating at different locations in the country, mostly in rural and remote areas. The project duration is for 18 months from April 2010 to September 2011 with a budget of US$ 214 760.

The programme activities of FPAB consist of awareness-raising and clinic-based services for quality MR services. The project has been implemented at six Reproductive Health Centres of FPAB in six districts, namely Barisal, Chittagong, Sylhet, Jhalakati, Magura and Netrokona. Reproductive health promoters (RHP) have been used for disseminating key messages to the community.

5.2 **Progress/Status of implementation**

All activities in the first quarter (15 April 2010 to 14 July 2010) were conducted as per the agreed workplan and timeline. The MoUs between FPAB and selected local NGOs, volunteers groups and hospitals/clinics were signed for referral services from the community to project clinics and to other hospitals and clinics.

Reproductive health promoters (RHPs) (community workers recruited by FPAB) have been identified and trained to promote community-raising awareness in rural areas. However, the recruitment was delayed at some of the site locations. The health education sessions mainly focused on FP, SRHR, MR and VAW messages for women of reproductive age. These messages are also provided to the general community, which includes men of all ages. In addition, health providers at clinics were trained to provide information and services to increase use of post-MR modern contraceptive methods.
Baseline KAP surveys were conducted in all six project sites and lack of correct knowledge on safe MR services and post-MR contraception was consistently found.

5.3 Facilitating factors

FPAB has experience in implementing field activities and providing clinical services for FP and RH services. Field workers who provide contraceptives in the community are important communicators to disseminate messages on MR to women. In addition, the signing of formal MoUs with identified hospitals/clinics facilitated referral services.

5.4 Challenges

The FPAB project has been conducted in remote and underserved areas, which proved to be challenging. Furthermore, the identification, recruitment and retention of project staff (community volunteers and RHPs) in hard-to-reach areas are added challenges.

A pregnancy test is often demanded by the client seeking MR, posing a challenge for the service provider. The MR procedure by definition excludes any pregnancy test; therefore, the client must understand this premise of the MR procedure and not demand a pregnancy test.

5.5 Findings and recommendations

The MTR team observed an information dissemination session by RHPs in a slum area of Sylhet and noted that RHPs need to improve their skill in facilitating health education group sessions. Senior staff of FPAB were requested to accompany the MTR team to observe the programme activities of MSCS the following day. The field staff from FPAB could also visit field staff at MSCS project sites to observe communication sessions.

Recommendation: The training workshops for RHPs of FPAB need to emphasize techniques for conducting interactive and participatory group sessions and using IEC materials effectively.
FPAB convinced the city counsellors of the relevance of dissemination of information on SRH and MR to the community. The city counsellors provided office space free of charge for their orientation and training activities (Box 5).

**Box 5:** Male Reproductive Health Promoter in Sylhet (project site of Family Planning Association of Bangladesh): “We believe that reproductive health information and particularly MR is important to disseminate to the women in this community. The City Counselors support the project and have given us this office space to conduct our orientation meetings.”

*Figure 9: Health education session and meeting with volunteers at city counsellor’s office*

6. **Bangladesh Association for Prevention of Septic Abortion (BAPSA): Demand generation for safe MR services and reduction of unsafe MR in rural areas of Bhola district under Barisal division, Bangladesh**

6.1 **Short description of the project**

The Bangladesh Association for Prevention of Septic Abortion (BAPSA) is an NGO that works on unsafe abortion, reproductive health services, adolescent health and MR. At the request of DGFP, the Bhola district of Barisal division in the southern part of Bangladesh was selected for this project because the target groups are poor and vulnerable women living in a hard-to-reach area. The project is for a total duration of 18 months (April
2010 to September 2011) with a budget of US$ 163 100. Since BAPSA was requested to move and set up operations in a new, hard-to-reach area, the project started late (in July 2010).

The overall objective is to prevent unwanted pregnancies by creating awareness of FP methods and prevention of unsafe MR through a multi-stakeholder partnership, delivering quality and safe MR and providing information on prevention of unsafe MR and SRHR. Activities include raising community awareness on unsafe MR, safe MR and SRH services through peer educators, family planning workers and other service providers of MR facilities, microcredit NGOs, female upazila members, and female school and college teachers. Key decision-makers, formal and informal leaders and gatekeepers are also targeted. The modalities employed were meetings with community members, awareness creation sessions, folk songs, popular theatre and other cultural events. Distribution of IEC materials and information dissemination was also carried out at community-level information centres (CICs).

6.2 Progress/Status of implementation

Project implementation was delayed due to difficulty in recruitment of staff, establishing a new office, and delay in receiving supplies and logistics. It is, however, expected that the activities will be implemented within the agreed time-frame. Staff recruitment and field coordination are in place and supplies and IEC/BCC materials have been obtained. A quarterly progress report has been submitted (December 2010) and is under review by WHO CO.

7. International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B): Sociocultural aspects and women’s perceptions on menstrual regulation and menstrual regulation services in Bangladesh

7.1 Short description of the project

ICCDR,B is a research organization with experience in conducting research on maternal and reproductive health including unsafe abortion and MR for
over 35 years. A variety of geographic locations, socioeconomic status (including religious backgrounds), and ethnicity were considered in selecting the study sites. The study population includes slum dwellers at Komolapur, Dhaka division, tribal population at Mirersharai, Chittagong division (hilly south-western region of Bangladesh) and coastal communities in Shaymnagar, Kaligonj, Satkhira division (a region in the southwest of Bangladesh) and Kanaighat, Sylhet division (a relatively more conservative subdistrict in the district) were also selected. The project is for a total duration of 17 months starting from April 2010 with a budget of US$ 137,700.

The main objective of this project is to describe the sociocultural aspects and women’s perception on MR and MR services that effect utilization of these services in Bangladesh, and to explore providers’ perspectives on access and quality of MR care and services. The study methods are focus-group discussions, in-depth interviews and semi-structured interviews. The key informants are identified during focus group discussions, through snow-balling technique (where existing study subjects suggest future subjects from among their acquaintances) and exit interviews of clients at MR clinics.

7.2 Progress/Status of implementation

The project implementation started late and is now progressing as per the agreed time frame. The release of funds was initially delayed due to differences in administrative procedure and financial reporting between WHO and ICDDR,B.

Section IV: Overall observations and recommendations for the MR Initiative

1. Implementation issues of the MR Initiative and services

1.1 Government-led Initiative

The MR project is a government-led Initiative in partnership with NGOs for rights-based awareness creation on SRHR, FP, MR information and safe services. The “supply” of MR and FP services is provided at public sector
facilities at the district and upazila levels and in NGO clinics where such services exist.

1.2 **Wide geographic coverage and diverse target groups**

The project is implemented in various geographical areas covering urban, rural and hard-to-reach areas of Bangladesh. Activities are implemented in urban slums of Dhaka city; hill tracts in the Chittagong district; the religious and conservative Sylhet division bordering with India; cyclone-prone coastal districts such as Satkhira; and flood-prone delta districts of Bhola. Marginalized, poor and vulnerable populations are particularly targeted for the interventions.

Each NGO partner had prior experience in working with a specific target audience, (e.g. Light House with high-risk populations on HIV prevention, and Phulki with garment factory workers on maternal and newborn health issues). Therefore, their previous contacts with these populations enabled them to smoothly integrate additional messages on SRH, MR and VAW.

1.3 **IEC/BCC materials**

*Agreement on IEC messages*

There is uniform consensus among all MR NGOs on the key messages for prevention of unwanted pregnancy with use of FP methods, MR services ("right place, right time and right person"), post-MR contraception, prevention of adolescent marriage and early pregnancy and prevention of violence against women. The Clients Charter of Rights developed by the MOH in 1998 was used to reinforce the rights-based approach in seeking and receiving services.

Technical discussions and joint work between WHO and the pre-selected applicants during the proposal development phases played an important role in streamlining the core MR/SRH messages across all projects. All implementing partners agreed on seven core standard messages which were delivered to the target audiences with clarity and consistency.
Table 2: Messages in IEC/BCC materials

<table>
<thead>
<tr>
<th>Six core messages to be disseminated</th>
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<tbody>
<tr>
<td>(1) Family planning for prevention of unwanted pregnancy</td>
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<tr>
<td>(2) MR services:</td>
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<tr>
<td>➢ Right time for MR services</td>
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<tr>
<td>➢ Right place for MR services</td>
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<td>➢ Right person for MR services</td>
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<td>(3) Post-MR contraception</td>
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<tr>
<td>(4) Prevention of adolescent marriage</td>
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<tr>
<td>(5) Delay in first pregnancy</td>
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<td>(6) Prevention of violence against women</td>
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</table>

Adaptation and flexibility in development of materials

A variety of IEC/BCC materials were developed (e.g. leaflets, stickers, brochures, poster and flip charts). Flip charts and some posters with pictorial depiction of the messages were developed for the less literate population. Most of these materials carried common messages except with variation in the colours, background pictures or organizational logos (Annex G) in an attempt to standardize the MR IEC/BCC materials so as to heighten recognition of the MR project nationwide. Similar uniform and consistent IEC/BCC messages are incorporated in songs and dramas.

1.4 Private public partnership

The principles of private public partnership were observed in different activities. The spirit of collaboration was evident for both the administrative and health authorities at the district and upazila levels. While the public sector has provided strong support to the NGOs for conducting their activities, the service delivery by the public sector in turn has been strengthened by the implementation of the MR programmes by the NGOs.

The mechanisms of collaboration extend from training of public and private service providers, to awareness-raising activities for the target
population groups at district and upazila levels, to establishment of functional referral services for MR complicated cases. IEC activities have led to demand generation for MR and FP services at the public sector facilities. Training of public sector workers, i.e. family welfare visitors (FWVs) of DGFP and health assistants of DGHS, was conducted by the NGOs. The training reinforced the rights-based demand for services from the perspective of the providers, raising respect for the clients and contributing to improving quality of services.

Support from the local leaders in the community led to the institution of cost-saving measures, e.g. the permission to use office premises and meeting rooms for meetings.

1.5 Approaches for dissemination of information and monitoring

Variety of approaches

A multi-pronged approach, "casting the net wide", is adopted to ensure that the critical segments of society are targeted: female community support groups (FCSG), elected female representatives, key decision-makers (male and elected female leaders and religious leaders), government and NGO field workers, teachers and microcredit NGO workers.

Reinforcement of training

The general approach was that initial training of target groups or health workers would be reinforced by either refresher training (eight months post-training) or follow-up meetings on a quarterly basis. The routine monthly reporting system of health workers (FWV/FWA and HA) was used to include reporting on MR Project.

Monitoring of community dissemination of information and MR services

Monitoring of safe MR services, post-MR contraception and the use of family planning among women under the MR Initiative by hospital registration or referral slips is fundamental. A systematic method has been employed to ensure that the messages were disseminated to the
community by each community social group (CSG) member or community mobilizer/promoter. The NGO staff reviewed the entries in the diaries of the individual CSG members on a monthly basis to see whether the target numbers of community women were sensitized. This interaction between NGO staff and the CSGs provided an opportunity to reinforce the information and replenish the stock of IEC/BCC materials.

### 1.6 Effect of community awareness activities

Reports from NGOs and interviews during field visits indicated that more women were seeking safe MR services. Shushilan reported that the increasing awareness of the community on safe MR services led to the closure of an illegal clinic where MR services were provided by an untrained person. Likewise, DDFP of Moulvibazar at MSCS project highlighted a positive response to the project and increased awareness of the community.

### 1.7 Collegial relationship between NGOs

One of the three NGOs selected in the first round of proposals for the Challenge Fund, the Marie Stopes Clinical Services, shared their experiences in training of community volunteers and service providers with other NGOs, who made site visits to observe the training and activities.

### 2. Challenges and recommendations

#### 2.1 Component 1: Scaling up delivery of quality MR services

Service delivery activities under Component 1 were implemented at different levels of the public health facilities, NGO clinics and private clinics/hospitals. Availability of competent/trained staff, supplies, infection prevention procedures and a functioning referral system contribute to quality of care. The nonjudgmental attitude of providers with good communication and interpersonal skills is critical for MR services. The differences in infrastructure and competency of MR providers, availability of supplies, and logistics resulted in varying levels of quality of service delivery.
Availability and quality of MR service provision in the public sector

Despite the progress made, the quality of MR services in the public sector remains a challenge. Through the demand generation side of the MR project, there could be an increased client load in the facilities of the public sector. Hence the issue of shortage of providers in the public sector, especially FWVs, should be addressed. In addition, financial accessibility to safe MR services was hampered due to the practice of unofficial fees, which in turn resulted in clients seeking unsafe services for a lower fee.

**Recommendation:** MR services in the public sector should be provided free to women who have FP method failure. Though this policy exists, it might not be strictly followed. Policy-makers at central and local levels will need to ensure that this policy is actively reinforced.

Evidence suggests that the reuse of MR kits is a common practice in both public and private clinics in Bangladesh. Improper sterilization and poor infection prevention lead to high risks of complications from infection and gynaecological morbidities. When the reuse of the cannulae or aspirators is carried out, there should be clear guidelines for the sterilization and reuse of these instruments and on when the cannulae or aspirators should be replaced.

**Recommendation:** The issue of reuse of MR cannulae needs urgent consideration for action. Highlighting infection prevention, implementing guidelines on infection prevention and sterilization techniques, and instructions for reuse and replacement of MR kits \(^{13}\) will contribute to improve safety and quality of the MR services.

The MTR team had an opportunity to share the main findings with DGFP and exchange views on a number of important policy and programme. The Programme Manager and Deputy Programme Manager of DGFP agreed that a shortage of FWVs is an issue of concern. This was attributed to the change in funding source for training, and to address the issue DGFP planned to re-start fresh recruitment and training of FWVs in 2011. DGFP has attempted to maximize utilization of the DGHS staff (health assistants) for provision of FP services and provide training for postpartum contraception, including insertion of IUDs.

\(^{13}\) At the time of the MTR mission, the DGFP had initiated development of national MR guidelines.
DGFP expressed willingness to develop and test demand-side financing (DSF) based on the successful experience of DGHS for the delivery/childbirth services\textsuperscript{14} for the MR services. DGFP will, however, be cautious, as such an intervention will require policy changes.

DGFP feels that the MR Initiative has the potential to enhance public private partnership by encouraging the establishment of more NGO clinics for provision of FP and MR services to underserved populations in order to complement the efforts of the public sector.

Reporting of MR services

Inaccurate and under-reporting of MR has been observed at both public and private clinics. The under-reporting in the public sector is partly due to unofficial fees being charged by FWVs for procedures performed outside of government settings. This under-reporting affects the procurement and supplies of MR kits and contraceptives. Incomplete reporting also poses challenges for MR NGOs in their analysis of project outcomes to observe the change in service utilization and indicators of service quality (Box 4).

**Recommendation:** The project information systems established by the NGOs under the MR Initiative have the potential to generate local information on demand and MR service utilization. Furthermore, efforts should be focussed on streamlining the project monitoring and information mechanisms to capture the association between demand-creation activities and service utilization trends. Mechanisms need to be in place to improve reporting from the public sector clinics.

Project evaluation on quality of services

The MTR team observed some successful examples where project activities on rights-based demand generation led to an increased number of clients to the public and NGO clinics. The beneficiaries, community leaders and local governments expressed their appreciation for the work done and requested an extension and expansion of the project activities. Scaling up of the proven best approaches should be sought, and resources for DGFP and MR

\textsuperscript{14} DSF- demand side financing, a scheme for delivery/childbirth services, initially piloted by DGHS with the technical assistance of WHO and now being considered as a policy in Bangladesh.
NGO activities should be mobilized. Supervision and monitoring of quality and safety of MR services are required.

**Recommendation:** Project monitoring mechanisms for MR services by DGFP should be streamlined to analyse service utilization data. Quality and safety of MR services should be included in the monitoring.

### 2.2 Component 2: Enhancing rights-based demand generation for safe MR services

The creation of rights-based demand for information and services for RH, including MR information and services by the different NGOs in a government-led Initiative, has progressed well. The MR Initiative covered diverse geographic areas and various target groups (Annex H).

A consultative process was followed in the development of IEC/BCC materials among the three NGOs who were funded in the first call for proposals. As a result, key messages for menstrual regulation, family planning and combating violence against women were consistently conveyed to the NGO and Ministry of Health staff as well as to volunteers implementing the project in the field. Posters, pamphlets and brochures with the same messages were used with the logos of the Ministry of Health, the Government of the Netherlands and WHO, with the logo of the respective NGO displayed side-by-side. The similarity of materials ensured easy recognition of the MR project.

The IEC/BCC messages were communicated using (a) various platforms (meetings, drama/songs, written messages in poster/leaflet/brochure and verbal communication); (b) different target audiences in homogeneous groups such as adolescents, community women and in mixed groups of men and women); and (c) a range of approaches (one-time communication, repeated messages through refresher training/sessions, or dissemination of only one message at a time over a period of regular intervals with the same group with reinforcement of earlier given messages).

**Recommendation:** The same IEC/BCC materials and approaches for training and dissemination were used by the four NGOs receiving support in the second call for proposals. The replication of processes in development
and dissemination of IEC materials by these NGOs and to public sectors could be regarded as a scaling up of Component 2 on demand generation.

2.3 Component 3: Improving the knowledge and evidence base on unsafe abortion, MR and other sexual and reproductive health and rights issues, and documenting the scaling-up of services responsive to findings

The number and quality of research proposals submitted for funding is limited. However, those submitted address critical issues relevant to the programme. The proposal "Sociocultural aspects and women’s perceptions on menstrual regulation and MR services in Bangladesh" is approved for implementation.

Recommendation: To strengthen national capacity in formulation and implementation of research studies. However, currently this is beyond of the scope of this Project. The recommendation is to be considered by the Government and development partners and could be part of the Initiative in the future.

2.4 Component 4: Strengthening the policy response

While the implementation of the MR project in many areas of the country for diverse population groups is a positive start, the broader framework of scaling up will need to be considered. As many actors are involved in this government-NGO partnership, the coordinating role of DGFP is critical, and could extend to obtaining political support for policies at the national level and ensuring budgetary allocation. The DGFP and the Coordination Committee of MR Associations in Bangladesh (CCMR,B) could take the lead for institutionalization of the MR Initiative.

The importance and relevance of the MR project was acknowledged and emphasized in meetings with the DGFP and the community representatives. Many expressed that such awareness-raising activities should be scaled-up on a broader scale throughout the country. The immediate concern is the continued sustainability of the project. This has been addressed to some extent through employing volunteers who receive no remuneration for their efforts. The spirit of helping the community, fulfilling a sense of social responsibility and being of service to their fellow
citizens serves as a strong motivating factor. While this holds true to a certain extent, it is natural that some of the volunteers would rotate off and would need to be replaced by new volunteers.

**Recommendation:** The leadership and engagement of DGFP is important in implementing programmes on reproductive health information and services. The NGOs implementing the projects under the MR Initiative look forward to enhanced engagement from the Ministry of Health. These NGOs, WHO and other major stakeholders need to ensure that dialogue with policy-makers and high-level programme managers occurs in order to ensure the sustainability of the project. In this regard, strong political commitment and innovative measures will be required due to the sensitive nature of the issue. As the Initiative was able to generate a momentum, development of a formal scaling-up strategy would be useful to sustain and enhance progress.

### 2.5 End-of-project evaluation

To ensure the evidence-based output and outcome of the project, an evaluation of improvement of awareness and knowledge and change in practices on the prevention of unwanted pregnancy unsafe abortion, MR services, sexual and reproductive health and rights issues will be required.

**Recommendation:** An evaluation to assess the impact of different kinds of demand generation and service provisions models used by the implementing partners should be carried out.
### Table 3: Summary of Findings and Recommendations

<table>
<thead>
<tr>
<th>Agency - role</th>
<th>Findings of MTR</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DGFP:</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
| **Stewardship and coordination:** DGFP is a chair of TAC and CCMRR,B         | DCGP plays a pivotal role in supporting the implementation of the MR Initiative and establishing effective linkages with MR implementing partners locally. There are areas that can strengthen the role of DGFP. | The DGFP’s role could be strengthened by  
  1) Using of the platform of this Initiative to establish/monitor quality improvement processes for safe MR services in response to increasing community awareness and demand for MR services.  
  2) Formulating and implementing a plan for human resources development and skill training to address a shortage of FWVs/FWAs against the established posts in the public sector. This may be considered in collaboration with Directorate General of Health Services (DGHS) to optimize existing resources of the MOHFW.  
  3) Implementing a strategy for the use of standardized IEC/BCC materials in public-private sectors.  
  4) Implementing joint DGFP-WHO field monitoring and supervision visits to project sites. |
| **Selection of grants:** DGFP is a member of a Working Group for final selection of grant proposals |                                                                                |                                                                                 |
| **Implementation:** DGFP is in charge for the development of the national MR guidelines, centralized supply of contraceptives commodities, with DDFPs facilitates implementation in the project sites |                                                                                |                                                                                 |
| **WHO:**               |                                                                                |                                                                                 |
| **Technical role:** review and feedback on proposals, monitoring and supervision of grant projects, technical inputs on project products (IEC/BCC, guidelines) | WHO administrative platform, rigorous review mechanisms required a considerable lead time for the review of documentation and release of funds by WHO to MR partners. In certain circumstances, rigid budget planning may jeopardize project implementation and management. | WHO as a managing agency should take into account the administrative processes and lead times in the future to avoid delays in the start-up and implementation of the projects and timely utilization of funds. In-built contingency or any other mechanism should be considered in the planned project budget to address legitimate unforeseen expenditures by the implementing partners. On-going and future activities under each component should be reviewed to meet the revised budget and plan of action. Site visits by the WHO proved to be useful and should be continued on a regular basis to provide technical support and capacity building. |
| **Managing role:** administering call for proposals and selection process, concluding contracts, disbursement of funds, assuring implementation and reporting as per workplans, coordination with implementing partners. |                                                                                |                                                                                 |
| **Role in implementation:** procurement of services and goods. |                                                                                |                                                                                 |

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15 This recommendation was derived from the observations and meetings with the implementing NGO partners, namely Light House and Shushilan and incorporated under the WHO part as to consider budget planning flexibility in-built to address contingencies.
## Mid-term review report

### Implementation of individual projects under challenge fund by NGOs and ICDDR,B

<table>
<thead>
<tr>
<th>Agency - role</th>
<th>Findings of MTR</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lighthouse</strong></td>
<td>Activities progress well as per workplan.</td>
<td>Community mobilizers should be encouraged to use interactive methods to be able to engage the audience and increase participation during group sessions. Close monitoring and technical supervision of the project implementation should be continued by Light House. To strengthen training and technical supervision Light House may need to identify an experienced staff to follow-up on this. This is especially important should the project plan to continue and/or expand. For future activities, the time required for development, testing, obtaining clearance, printing and dissemination of IEC materials would need to be considered prior to the start of project implementation. In addition to using referral slips for case identification under the project, the slips can also be used for monthly monitoring of MR service utilization in any public, private or NGO clinic providing services under the project.</td>
</tr>
<tr>
<td>Improving access to MR services for marginalized and underserved in Bogra and Rajshahi</td>
<td>Recommendations from WHO technical monitoring visit on strengthening facilitation skills of community mobilizers and structuring target audience yet to be addressed. Difficulties (demanding schedules, uncompetitive salary package) in keeping project staff motivated were recognized.</td>
<td></td>
</tr>
<tr>
<td><strong>Shushilan</strong></td>
<td>Activities progress well as per workplan though initially affected by the cyclone Aila. Rights-based approach to generate demand for quality MR services, contraception and other RH services used by Shushilan is built on the principle “for community by community”. The strong partnership of Shishilan, the local government (DDFP) and the community should be regarded as a model for future implementation and scale up of the MR Project.</td>
<td>WHO in collaboration with DGFP may consider producing video materials of the Shushilan’s drama shows to share with other MR partners and to implement as part of the national IEC/BCC activities. The possibilities for offering a “one-stop” MR and FP services to women at the Nalta Hospital should be considered to increase the utilization of post-MR contraception and contribute to achieving the objectives of the MR Initiative. A monitoring mechanism to track service provision, post-MR contraception and other outcomes of awareness-increasing activities is needed. The format of the referral slips developed by Light House could be used as an example to collect and analyze information on numbers of women utilizing MR and post-MR FP services in both public and private health facilities as a result of demand-generation activities of the project. The issue of shortage of skilled MR service-providers needs to be addressed at the policy level to ensure availability and quality of services both at the public and private sector.</td>
</tr>
<tr>
<td>Improving access to MR services in rural Bangladesh thru rights-based approach in Satkhira and Khulna districts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marie Stopes Clinic</strong></td>
<td>Activities progress well as per workplan. The modality whereby female biology teachers incorporated SRH and MR information in their lectures in girls’ schools and colleges worked well. However, the dissemination of these messages in the co-educational schools proved more of a challenge.</td>
<td>The MSCS should hold further discussions with the teachers from the co-educational schools to strengthen information dissemination. Although the trained male teachers are interested to disseminate SRH messages to male students, it would require a different approach and additional IEC/BCC materials which may not be possible within the scope of the current project. MR NGOs would benefit from training of its project staff on interactive and participatory approaches and therefore various modalities for training should be considered by DGFP and other implementing partners. Among other options, the capacity of MSCS and their experience in training should be considered and explored for training needs in MR.</td>
</tr>
<tr>
<td>Public-private partnership in improving safe MR in Narayanganj and Dhaka, and in Feni district</td>
<td></td>
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<tr>
<td>Agency - role</td>
<td>Findings of MTR</td>
<td>Recommendations</td>
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</tr>
<tr>
<td><strong>Phulki</strong></td>
<td>Activities progress well as per workplan. Phulki developed a participatory approach in the selection of master trainers and peer educators. A “second-line” group of trainers and peer educators was trained to meet the needs of factory workers for awareness creation.</td>
<td><strong>Regular orientation and advocacy</strong> events of Bangladesh Knitwear Manufacture and Exporters Association (BKMEA) and Bangladesh Garments Manufacture and Exporters Association (BGMEA) are important and these should be ensured early in the project inception phase.</td>
</tr>
<tr>
<td><strong>FPAB</strong></td>
<td>Activities progress well as per workplan. RHPs need to improve their skills related to facilitation of health education sessions.</td>
<td>The <strong>training workshops</strong> for Reproductive Health Promoters (RHP) of FPAB would need to emphasize the techniques of conducting <strong>interactive and participatory group sessions</strong> and using of IEC materials effectively.</td>
</tr>
<tr>
<td><strong>BPASA</strong></td>
<td>Started July 2010 - too early for assessment</td>
<td>None</td>
</tr>
<tr>
<td><strong>ICCDR,B</strong></td>
<td>Started July 2010 - too early for assessment</td>
<td>None</td>
</tr>
</tbody>
</table>

**Overall recommendations**

| Component 1 | The difference in infrastructure and competency of MR providers, infection prevention procedures, availability of supplies and access to referrals resulted in varying degree of quality. The quality of MR services is challenged due to a shortage of trained providers (FWVs) and financial accessibility. Under-reporting of MR cases has been observed, which affects the forecasting and central procurement of MR kits and contraceptive supplies. | MR services in the public sector are to be **provided free** to women who have FP method failure. Though this policy exists, it might not be strictly followed. Policy makers at central and local levels will need to ensure that this policy is actively reinforced. The issue of **reuse of MR cannulae** needs urgent consideration for action. Highlighting infection prevention, implementing guidelines on infection prevention and sterilization techniques, and instructions for reuse and replacement of MR kits will contribute to improve safety and quality of the MR services. Underreporting affects the procurement and supplies of MR kits and contraceptives. The project **information systems** established by the NGOs under the MR Initiative have the potential to generate local information on demand and MR service utilization. Furthermore, efforts should be focused on **streamlining the project monitoring** and information mechanisms to capture the association between demand creation activities and service utilization trends. Mechanisms need to be in place to improve reporting from the public sector clinics. |

|
### Agency - role

<table>
<thead>
<tr>
<th>Findings of MTR</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project monitoring mechanisms for MR services by DGFP should be streamlined to analyze service utilization data. Quality and safety of MR services should be included in the monitoring.</td>
<td></td>
</tr>
</tbody>
</table>

**Component 2**  
Enhancing rights-based demand generation for MR services  
The IEC/BCC materials were endorsed by the DGFP. Standardized IEC/BCC materials and approaches for training and dissemination were used by the four NGOs receiving support in the second Call for proposals.  
The replication of processes in development and dissemination of IEC materials by these NGOs and to public sectors could be regarded as a **scaling up of Component 2** on demand generation.

**Component 3**  
Improving the knowledge and evidence on unsafe abortion  
The number and quality of research proposals submitted for funding was limited. Only one research study has been approved for implementation.  
To strengthen **national capacity in formulation and implementation of research studies**. However, currently this is beyond of the scope of this Project. The recommendation is to be considered by the Government and development partners and could be part of the Initiative in the future.

**Component 4**  
Strengthening the policy response  
The leadership and engagement of DGFP is important in implementing programmes on reproductive health information and services.  
The NGOs implementing the projects under the MR Initiative look forward to enhanced engagement from the Ministry of Health. These NGOs, WHO and other major stakeholders need to ensure that **dialogue** with policy makers and high-level programme managers occurs in order to ensure the sustainability of the project. In this regard, strong political commitment and innovative measures will be required due to the sensitive nature of the issue. As the Initiative was able to generate a momentum, **development of a formal scaling-up strategy** would be useful to sustain and enhance progress.  
An **evaluation** to assess the impact of different demand generation and service provisions models used by the implementing partners should be carried out.
4. Conclusion

In Bangladesh, the maternal mortality ratio was 338 per 100,000 live births in 2008, of which one fourth is due to unsafe abortion. The project on Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh (the MR Initiative) was formulated to contribute to achievement of MDG 5 to reduce maternal mortality by three quarters by 2015, with 1990 as the baseline. The purpose of the Initiative is to ensure equitable access to services for prevention of unsafe abortion in both urban and rural areas. Therefore, four key components were identified in the call for proposals under the MR Initiative. These are:

- **Component 1:** Scaling up delivery of quality MR services
- **Component 2:** Enhancing rights-based demand generation for safe MR services
- **Component 3:** Improving the knowledge and evidence base on unsafe abortion, MR and other sexual and reproductive health and rights issues, and documenting the scaling-up of services responsive to findings
- **Component 4:** Strengthening the policy response

The majority of the proposals addressed components 1 and 2 and the implementation has progressed well within the short time frame. Public private partnerships have been strengthened and vulnerable populations were targeted. Clear and consistent messages for critical reproductive health issues, with a focus on preventing unwanted pregnancy, unsafe abortion and safe MR services, have been developed and widely disseminated. Efforts have been made to ensure safe and affordable MR services. The MTR team acknowledges the enthusiasm of community volunteers for raising awareness and demand generation using IEC/BCC messages, the commitment of service providers, and the keen interest of beneficiaries towards the Initiative.

Despite the achievements, DGFP, the NGO partners and WHO note the challenges in implementing the project such as factors related to human resources as well as to supplies and equipment. An additional concern of all
partners and the beneficiaries is the sustainability of the Initiative. Although some mechanisms for sustainability have been built into the project, political commitment and funding will be required to build on the gains made to ensure that the rights-based approach to SRH information and services continues. It is hoped that under Component 4, this issue can be addressed. This component includes development of guidelines, recruitment of public sector service providers and training on MR procedures. The MTR team recommends a heightened focus on this Component in the remaining period of the MR Initiative.
**Annex A: MTR assessment tools**

A Mid-term Review of the Netherlands-funded project
“Strengthening the National Menstrual Regulation Programme in Bangladesh”

The project will be reviewed by an international external consultant, and national external consultant. WHO headquarters and the Regional Office will be part of the review team, while the WHO Country Office Technical Officer-Maternal Health (TO-MH) will be responsible for liaison, coordination and programmatic/technical feedback. The following sources will be used: (1) document review; (2) field observation; (3) stakeholder meeting; and (4) key informant interviews (project managers implementing the Challenge Fund’s grants, WHO CO staff, DGFP national-level staff, local officials, MR providers/clinic managers or clients, if possible). The documents reviewed include: project proposal/applications, office reports/records, communications, progress reports and results of related project surveys (baseline surveys).

<table>
<thead>
<tr>
<th>Interviewer’s name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Date of interview</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Respondent’s full name</th>
<th></th>
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<tbody>
<tr>
<td>Designation/contact details</td>
<td></td>
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</tbody>
</table>

**PART I: MR project information**

<table>
<thead>
<tr>
<th>1.1 Official Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Funding organization:</td>
</tr>
<tr>
<td>1.3 Duration of the project:</td>
</tr>
<tr>
<td>(as per MoU)</td>
</tr>
<tr>
<td>1.4 Official start date:</td>
</tr>
<tr>
<td>1.5 Official completion date:</td>
</tr>
<tr>
<td>1.6 Purpose/ objectives:</td>
</tr>
<tr>
<td>1.7 Planned budget:</td>
</tr>
<tr>
<td>1.8 Allocated funds (what funds are available to the project?):</td>
</tr>
<tr>
<td>1.9 Any revisions in the project document (describe what, when, reasons, and if complete):</td>
</tr>
<tr>
<td>1.10 Overall assessment of the progress towards achievement of the objectives:</td>
</tr>
</tbody>
</table>
PART 2: MR project background (to be completed by evaluation team)

2.1 Historical background and setting in which the project was designed
2.2 Technical relevance of the project to the country context
2.3 Underlying principles of the project (rights-based demand for MR services for the underserved population; public-private partnership; innovation, sustainability)
2.4 Describe the design of the project: Challenge Fund
2.5 Key interventions/identified components:
   1 - Scaling up delivery of quality MR service
   2 - Enhancing rights-based demand generation for safe MR service
   3 - Improving knowledge and evidence base on SRH and right issues
   4 - Strengthening the policy response
2.6 Geographic areas where the interventions delivered were in accordance with the objectives of the call for proposals

PART 3: Project governance by DGFP

<table>
<thead>
<tr>
<th>Review question</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Did DGFP fulfil the role with regard to stewardship?</td>
<td>Yes/No (describe how, mechanisms used)</td>
</tr>
<tr>
<td>3.2 Did DGFP fulfil the role with regard to coordination among MR stakeholders for quality and timeliness? Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>3.3 Did the three committees proposed in the project document fulfil their roles and responsibilities in accordance with the terms of reference?</td>
<td>Yes/No (describe, including alterations to committees in the course of implementation if any)</td>
</tr>
<tr>
<td>• Coordination Committee for MR Agencies in Bangladesh</td>
<td></td>
</tr>
<tr>
<td>• Technical Advisory Committee for MR Activities</td>
<td></td>
</tr>
<tr>
<td>• Steering Committee for promotion of MR services</td>
<td></td>
</tr>
<tr>
<td>3.4 Was DGFP involved in the selection of grant applicants?</td>
<td>Yes/No (describe how, mechanisms used)</td>
</tr>
<tr>
<td>3.5 Did DGFP fulfil the role in implementing the project?</td>
<td>Yes/No (activities carried out, if any)</td>
</tr>
<tr>
<td>3.6 Any challenges and recommendations</td>
<td></td>
</tr>
</tbody>
</table>
### PART 4: Project management by WHO

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Did WHO fulfil the role of review and selection of applicants?</td>
<td></td>
</tr>
<tr>
<td>Was the process for identifying and assessing the proposals set out and carried out efficiently?</td>
<td></td>
</tr>
<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.2 Did WHO fulfil the administrative arrangements?</td>
<td></td>
</tr>
<tr>
<td>Were the contracts prepared and funds released in a timely manner?</td>
<td></td>
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<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
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<tr>
<td>Was the staffing process adequate?</td>
<td></td>
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<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.3 Did WHO fulfil the role of technical support?</td>
<td></td>
</tr>
<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.4 How were the MR projects monitored?</td>
<td></td>
</tr>
<tr>
<td>• Was there an overall workplan?</td>
<td></td>
</tr>
<tr>
<td>• How many monitoring visits were carried out for each project?</td>
<td></td>
</tr>
<tr>
<td>• What were the objectives of monitoring visits and were they met?</td>
<td></td>
</tr>
<tr>
<td>• Was feedback provided to the NGO partners?</td>
<td></td>
</tr>
<tr>
<td>• Was action taken on the feedback?</td>
<td></td>
</tr>
<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.5 Did WHO fulfil the role of coordination and communication with the donor (Netherlands Embassy, Ministry of Development Cooperation)?</td>
<td></td>
</tr>
<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.6 Did WHO fulfil the role of coordination and communication with the NGO recipients?</td>
<td></td>
</tr>
<tr>
<td>Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>4.7 Any challenges and recommendations</td>
<td></td>
</tr>
</tbody>
</table>


**PART 5: Implementation of projects under the Challenge Fund by MR partners**

1. **General information**

| 1.1 | Official title: |
| 1.2 | Implementing agency: |
| 1.3 | Duration of the project: |
| 1.4 | Official start date: |
| 1.5 | Official completion date: |
| 1.6 | Total planned budget: |

2. **Project description**

| 2.1 | Objectives: |
| 2.2 | Activities: |
| 2.3 | Geographical sites: |
| 2.4 | Target population: |
| 2.5 | Partnerships: |

3. **Assessment questions**

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Were the project’s objectives fulfilled through the public private partnership, right-based approach, behavioural change communication, in order to reach pro-poor or underserved populations overall in the MR Initiative? Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>3.2 Were the project activities carried out as planned and in a timely manner (according to the work plan)? Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>3.3 Was the project managed efficiently (mechanisms for management, implementation and coordination)? Any changes/amendments from the agreed proposal? Yes/No (describe how, mechanism used)</td>
<td></td>
</tr>
<tr>
<td>3.4 Was the project monitored efficiently? Any changes/amendments from the agreed proposal? Yes/No (describe how, mechanism used)</td>
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</tr>
<tr>
<td>3.5</td>
<td>What were the facilitating factors in the project?</td>
</tr>
<tr>
<td>3.6</td>
<td>What were the challenges in the implementation of the project?</td>
</tr>
<tr>
<td>3.7</td>
<td>How can you ensure the sustainability of the project?</td>
</tr>
</tbody>
</table>
| 3.8 | Assessment of documents (files/records/progress reports/communications)  
- Format of reports  
- Quality of reports  
- Timeliness of submission  
- Whether any changes were made to the initial project document |
| 3.9 | Are plans being developed now for future scaling-up? |
| 3.10 | Overall assessment  
- Implementation towards the objectives is on track  
- Implementation towards the objectives is lagging  
- Objectives are unlikely to be met  
If YES- Skip  
If partially met list future plans  
If not met give reasons |
|   | Any other comment from the interviewee |
|   | Any other additional notes/observations by interviewer |
| 3.11 | Opinions of NGO stakeholder on the role of WHO and DGFP  
What do you think the role of WHO is, and based on your opinion has the role been fulfilled?  
What do you think the role of the central/local government is, and based on your opinion has the role been fulfilled? |
# Annex B: Schedule of MTR

<table>
<thead>
<tr>
<th>#</th>
<th>Activities</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Meeting of MTR Team</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>Review and experience-sharing Workshop of all MR stakeholders</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>3</td>
<td>Travel to implementation sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Travel to Sylhet – FPAB and working on a report</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>b</td>
<td>Travel to Moulvibazar – Marie Stopes</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>c</td>
<td>Return to Dhaka – Phulki</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>d</td>
<td>Travel to Bogra – Light House</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>e</td>
<td>Travel to Satkhira-</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>f</td>
<td>Travel back to Dhaka</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>4</td>
<td>Conclude &amp; wrap up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-a</td>
<td>Analysis and concluding findings of mission</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>4-b</td>
<td>Debriefing with WHO staff, WR, donor and DGFP</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>Consultant report writing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Annex C: Agenda and list of participants

**Experience-sharing workshop among MR stakeholders, 28 November 2010, Dhaka, Bangladesh**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 10:00</td>
<td>Welcome and opening remarks</td>
</tr>
<tr>
<td></td>
<td>Objectives and Tentative agenda of the workshop</td>
</tr>
<tr>
<td></td>
<td>Introduction of participants</td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>National MR Programme: An overview of the current situation</td>
</tr>
<tr>
<td></td>
<td>Speech by Director, DGFP</td>
</tr>
<tr>
<td>11:00 – 13:00</td>
<td>Presentations and discussion</td>
</tr>
<tr>
<td></td>
<td>Sushilan (11:00 - 11:45)</td>
</tr>
<tr>
<td></td>
<td>Light House (11:45 – 12:30)</td>
</tr>
<tr>
<td></td>
<td>Marie Stopes Clinic Society (12:30 -13:15)</td>
</tr>
<tr>
<td>14:00 – 15:30</td>
<td>Presentations and discussion</td>
</tr>
<tr>
<td></td>
<td>Phulki (14:00 – 14:30)</td>
</tr>
<tr>
<td></td>
<td>Family Planning Association of Bangladesh (FPAB) (14:30 – 15:00)</td>
</tr>
<tr>
<td></td>
<td>Bangladesh Association for Prevention of Septic Abortion (BAPSA) (15:00 – 15:30)</td>
</tr>
<tr>
<td>16:00 – 16:30</td>
<td>Presentation and discussion</td>
</tr>
<tr>
<td></td>
<td>ICDDR,B</td>
</tr>
<tr>
<td>16:30 – 17:00</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Close of Workshop</td>
</tr>
</tbody>
</table>
List of participants

Experience-sharing Workshop among MR Stakeholders, 28 November 2010, Dhaka, Bangladesh

Dr. Sufi Zamal
Programme Director
Family Planning Association of Bangladesh (FPAB)
Mr. Fashiar Rahman
Programme Manager
Family Planning Association of Bangladesh (FPAB)
Dr Altaf Hossain
Director
Bangladesh Association for Prevention of Septic Abortion (BAPSA)
Mr Md Zubair
Consultant
Bangladesh Association for Prevention of Septic Abortion (BAPSA)
Mr Hedayatullah
Training Coordinator
Bangladesh Association for Prevention of Septic Abortion (BAPSA)
Ms Suraiya Haque
Executive Director
Phulki
Ms Salma Parvin
Project Manager
Phulki
Md Harun-or-Rashid
Chief Executive
Light House
Probir Kumar Das
Project Manager
Light House

Md Nasir Uddin
Monitoring & Evaluation Officer
Light House
Mr Mostaffa Nuruzaman
Director
Shusilan
Mr Sohidul Islam
Project Coordinator
Shusilan
Ms Dipali Biswas
Upazila Organizer
Shusilan
Mr. Anil P Tambay
Country Management Consultant
Marie Stopes Clinic Society (MSCS)
Dr. Kazi Golam Rasul
Director Program Development
Marie Stopes Clinic Society (MSCS)
Mr. Daulatuzzaman
Manager Resource Development
Marie Stopes Clinic Society (MSCS)
Mr. Korban Ali
Project Manager, Narayanganj
Marie Stopes Clinic Society (MSCS)
Mr. Masud Rana
Project Manager, Feni
Marie Stopes Clinic Society (MSCS)
Mr. Masudur Rahman
Project Manager, Moulvibazar
Marie Stopes Clinic Society (MSCS)
Mr. Abul Quiyume
Project Manager, Sherpur
Marie Stopes Clinic Society (MSCS)
Mr Nabeel Ashraf Ali  
(Focal Person)  
Principal Investigator Assistant Scientist  
International Centre for Diarrhoal Disease Research, Bangladesh (ICDDR,B)  
Ms Rashida Khan  
Assistant Investigator  
International Centre for Diarrhoal Disease Research, Bangladesh (ICDDR,B)  
Ms Shahnoor Akter Chowdhury  
Research Investigator  
International Centre for Diarrhoal Disease Research, Bangladesh (ICDDR,B)  
Dr Tippawan Liabsuetrakul  
International Consultant for MTR  
Prince of Songkla University Songkhla, Thailand  
Dr Md Nazrul Islam  
National Consultant for MTR  
Dhaka, Bangladesh  
Mushfiqua Z. Satiar  
Advisor, Gender and Development Embassy of the Kingdom of the Netherlands (EKN)  
Dr Ganesh Chandra Sarkar  
Director (IEM), Ag. Director General  
Director General of Family Planning Bangladesh  
Dr Tapash Ranjan Das  
Deputy Director MCH & Focal Point of MR, WHO  
Director General of Family Planning Bangladesh  
Dr Kazi Habibur Rahman  
Deputy Director, RH, DGHS  
Director General of Health Services, Bangladesh  
Ms Anna af Ugglas Nygreh  
Technical Officer, (Midwifery) United Nations Population Fund, Dhaka, Bangladesh  
Dr Katherine Ba-thike  
Area Manager for Asia and Pacific Department of Reproductive Health and Research, World Health Organization, Geneva  
Dr Akjemal Magtymova  
Medical Officer World Health Organization South-East Asia Regional Office, New Delhi, India  
Dr Jyoti Reddi  
Technical Officer World Health Organization, Office of the WHO Representative in Bangladesh, Dhaka  
Dr Frank Paulin  
Acting WHO Representative of Bangladesh World Health Organization, Office of the WHO Representative in Bangladesh, Dhaka
Annex D: List of key informants interviewed

Family Planning Association of Bangladesh
(1) Dr Sufi Zaman, Project Director, MR project,
(2) Mr Fashiar Rahman, Program Officer, MR project,
(3) Ms Maushumi Rani Roy, Reproductive Health Promoter
(4) Ms Namita, Community Volunteer
(5) Ms Nasrin Islam, Reproductive Health Promoter at Official Counsellor of Dinar Khan Hashu

Marie Stopes Clinic Society, Moulvibazar
(6) Dr Golam Rasul, Director of MSCS
(7) Mr Masud, Project Manager of MSCS, Moulvibazar
(8) Dr M.A. Hannan, acting DDFP
(9) Ms Sajeda Khatun, Field Organizer
(10) Selected teachers at Government Girls College, Moulvibazar Sadar
(11) Key decision-makers, Labour House, Sreemangal
(12) NGO field workers, Kamalganj Municipality Office
(13) Dr Gour Moni Sinha, Upazila Health Family Planning officer
(14) Mr Modhusudon Paul Chy, Upazila Family Planning officer

Phulki
(15) Ms Salma Parvin, Health Educator of Phulki
(16) Mr Alauddin Khan, Manager, Finery Garment
(17) Mr Dipak Dey, Welfare officer, Finery Garment

Light House
(18) Mr Harun Ur Rashid, CEO and Founder
(19) Ms Rokeya Khatun, Community Mobilizer
(20) Mst Shamima Akhter, Counselor at Khulna Mukti Sheba Sangstha (KMSS)
(21) Ms Umme Salma, Paramedic at Khulna Mukti Sheba Sangstha (KMSS)

Shushilan

(22) Mr Mostaza Nuruzzaman, Director of Shushilan
(23) Mr Sohidul Islam, Project Coordinator
(24) Ms Nildumur, Member of Shadhikar Group, Shyamnagar Upazila
(25) Mr Sheikh Abdur Rakib, Upazila Family Planning Officer
(26) Md Mojibur Rahman, Assistant Upazila Family Planning Officer
(27) Mr M.A. Bari, Upazila Chairman
(28) Mr Abdul Wahed, Chairman of Shadhikar General Committee
(29) Shuvoshakti (Youth) Group
(30) Dr Bappi Fazal Mahmud, Nalta Hospital
(31) Dr Golam Sarwar, Nalta Hospital
(32) Ms Safia, Health Educator
(33) Ms Arifa, Health Educator
(34) Representatives of beneficiaries at Kulia Union, Debhata
(35) Madrasa students, Parulia Madrasa
(36) Mr Liaqaut Ali, Chairman
(37) Mr Shahin Reza, Upazila Organizer
(38) Shushamaj members

Directorate General of Family Planning, Ministry of Health, Bangladesh

(39) Dr Mahbubur Rahman, Programme Manager MR project
(40) Dr Tapas Das, Deputy Programme Manager

World Health Organization Country Office for Bangladesh

(41) Dr Jyoti Reddi, Technical Officer for Maternal Health
## Annex E: Progress against indicators of selected\(^{16}\) projects implemented by MR NGOs

1. **Light House (Duration of the project: June 2009-May 2011)**

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>Targets for Jun 2009-Sep 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Indicators</strong></td>
<td>Target</td>
</tr>
<tr>
<td>number of project staff trained</td>
<td>17</td>
</tr>
<tr>
<td>number of community sensitization meetings</td>
<td>408</td>
</tr>
<tr>
<td>number of advocacy meetings</td>
<td>40</td>
</tr>
<tr>
<td>number of project facilitation team meetings</td>
<td>10</td>
</tr>
<tr>
<td>number of cultural shows</td>
<td>36</td>
</tr>
<tr>
<td>number of video shows</td>
<td>96</td>
</tr>
<tr>
<td>number of women attending one-to-one sessions</td>
<td>37180</td>
</tr>
<tr>
<td>number of women attending group sessions</td>
<td>4946</td>
</tr>
<tr>
<td>number of transportation for referral cases</td>
<td>130</td>
</tr>
<tr>
<td><strong>Service Provision Indicators</strong></td>
<td>Target</td>
</tr>
<tr>
<td>number of women received MR services</td>
<td>-</td>
</tr>
<tr>
<td>number of women received post-MR services</td>
<td>-</td>
</tr>
<tr>
<td>number of referral cases</td>
<td>-</td>
</tr>
<tr>
<td>number of post-follow up at clinic</td>
<td>-</td>
</tr>
<tr>
<td>number of post-follow up at field levels</td>
<td>-</td>
</tr>
<tr>
<td>number of women received FP services</td>
<td>-</td>
</tr>
</tbody>
</table>

---

\(^{16}\) The tables reflect the progress of the three projects selected under the 1\(^{st}\) call for proposals and only one project (FPAB) selected under the 2\(^{nd}\) call, as the remaining projects were at the commencement of their implementation.
2. **Shushilan (Duration of the project: June 2009-May 2011)**

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>Targets for Jun 2009-Sep 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Indicators</strong></td>
<td>Target</td>
</tr>
<tr>
<td>number of project staff trained</td>
<td>36</td>
</tr>
<tr>
<td>number of project facilitation team meetings</td>
<td>16</td>
</tr>
<tr>
<td>number of FP field workers attending advocacy meetings</td>
<td>203 (270)</td>
</tr>
<tr>
<td>number of Shwadhikar group members oriented</td>
<td>1450</td>
</tr>
<tr>
<td>number of Shwadhikar group members trained</td>
<td>522</td>
</tr>
<tr>
<td>number of Shushamaj members oriented</td>
<td>810</td>
</tr>
<tr>
<td><strong>Service Provision Indicators</strong></td>
<td></td>
</tr>
<tr>
<td>number of women received MR services</td>
<td>-</td>
</tr>
<tr>
<td>number of women received FP services</td>
<td>-</td>
</tr>
</tbody>
</table>

3. **Marie Stopes Clinic Society- Narayanganj (Duration of the project: June 2009-May 2011)**

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>Targets for Jun 2009–Sep 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Indicators</strong></td>
<td>Target</td>
</tr>
<tr>
<td>number of project staff oriented</td>
<td>10</td>
</tr>
<tr>
<td>number of project team meetings</td>
<td>7</td>
</tr>
<tr>
<td>number of female community support group members trained</td>
<td>371</td>
</tr>
<tr>
<td>number of women educated by female community support group members</td>
<td>26500</td>
</tr>
<tr>
<td>number of microcredit NGO workers oriented</td>
<td>120</td>
</tr>
<tr>
<td>number of microcredit targeted received SRH messages by microcredit</td>
<td>17140</td>
</tr>
<tr>
<td>number of locally elected female representatives sensitized</td>
<td>41</td>
</tr>
<tr>
<td>number of school/college teachers sensitized</td>
<td>100</td>
</tr>
<tr>
<td>number of students received SRH messages by teachers</td>
<td>1785</td>
</tr>
<tr>
<td>number of key decision makers sensitized</td>
<td>50</td>
</tr>
<tr>
<td>number of health and FP workers oriented</td>
<td>400</td>
</tr>
</tbody>
</table>
4. FPAB (Duration of the project: Apr 2010-Oct 2011)

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>Targets for Apr 2010 to Jul 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Indicators</strong></td>
<td>Target</td>
</tr>
<tr>
<td>number of on-job training sessions</td>
<td>3</td>
</tr>
<tr>
<td>number of project staff trained</td>
<td>45</td>
</tr>
<tr>
<td>number of clients surveyed for client-satisfaction</td>
<td>90</td>
</tr>
<tr>
<td>number of women received money support for MR services</td>
<td>33</td>
</tr>
<tr>
<td>number of sessions for providing information on FP</td>
<td>1080</td>
</tr>
<tr>
<td><strong>Service Provision Indicators</strong></td>
<td></td>
</tr>
<tr>
<td>number of women who received information and post-MR FP services</td>
<td>72</td>
</tr>
</tbody>
</table>
Annex F: IEC/BCC materials of MSCS

Leaflet: Clients’ rights to safe MR services
It is your right to get MR services timely, from right place, by the right service provider
Know about your rights:
- Right to choose treatments and family planning services
- Right to get emergency health services
- Right to get quality services with reasonable price
- Right to get safe health services
- Right to privacy and confidentiality
- Right to have respect, to provide opinion of services and to have congenial atmosphere
- Right to know information about all types of health services rendered from a service centre
- Right to inform concerned authority to get remedy, if the rights are not met
- Right to get copy of report of services received
- Right to know details about health services received

Poster: Safe MR –Do’s and Don’t’s

<table>
<thead>
<tr>
<th>What not to Do (Don’ts)</th>
<th>What to Do (Do’s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is safe for MR after 10 weeks from the 1st day of last menstruation</td>
<td>It is safe for MR within 6-10 weeks from the 1st day of last menstruation</td>
</tr>
<tr>
<td>Take MR services from any unauthorized health centre or NGOs/clinics</td>
<td>Come to govt. hospital or govt. approved NGOs/private clinics to take MR service</td>
</tr>
<tr>
<td>After MR Service, it is not mandatory to come to health service centre for follow-up</td>
<td>After MR Service, it is mandatory to come health service centre for follow-up</td>
</tr>
<tr>
<td>It is not necessary to take any family planning method after MR services</td>
<td>It is mandatory to take a family planning method after MR services</td>
</tr>
</tbody>
</table>
Leaflet: VAW
To make our family happy and build a better society, let us:
- Show due respect to every woman
- Take decisions jointly by participating men-women together
- Refrain ourselves from behaviour, comments and opinions that disrespect women
- Ensure women’s education in every home
- Stop sexual harassment
- Prevent adolescent marriage
- Abstain from taking and giving dowry

The Brochure (four pages):
1st (Cover page): Know about safe MR to live in good health

2nd page: Menstruation off for six weeks or more? Come quickly!!

3rd page: Right time for MR:
It is safe to take MR services between 6-10 weeks after the first day of last menstruation period.

Right place of MR:
- Government health centres
- Government-approved NGO health centres
- Government-approved private clinics

Appropriate service providers:
- Trained FWVs/ paramedics/ doctors (between 6-8 weeks)
- Trained doctors (between 6-10 weeks)

4th page: Accept family planning methods after doing MR to avoid unwanted pregnancy and live in good health.

To prevent unwanted pregnancy:
- Know about contraception
- Use an appropriate family planning method
## Annex G: Review of IEC/BCC materials

<table>
<thead>
<tr>
<th>S.No</th>
<th>Messages of IEC</th>
<th>MSCS</th>
<th>Shushilan</th>
<th>Light House</th>
<th>FPAB</th>
<th>Phulki</th>
<th>BAPSA</th>
<th>ICDDR,B*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MR Services: Right time</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>MR Services: Right place</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>MR Services: Right person</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Post- MR contraception</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Family planning for prevention of unwanted pregnancy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>Prevention of adolescent marriage</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>Delay in first pregnancy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>Prevention of violence against women</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>Do's and don'ts of safe MR services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*ICDDR,B conducts research so IEC materials are not applicable.
## Annex H: Summary of different approaches of NGO implementing partners

<table>
<thead>
<tr>
<th>NGOs</th>
<th>Target</th>
<th>Objectives</th>
<th>Partnership</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lighthouse</td>
<td>Female sex workers, MSM, female drug-users, and populations in slums and rural areas of Bogra and Rajshahi</td>
<td>To improve equitable access to services for prevention of unsafe MR for the targeted population</td>
<td>Khulna Mukti Sheba Sangstha (KMSS): pre-counselling, safe MR services, post-counselling - Government officials (Health &amp; FP Department) and TBA &amp; FWV/HA</td>
<td>Community mobilizers - IEC/BCC - Group sessions - Cultural shows</td>
</tr>
<tr>
<td>Shushilan</td>
<td>Women at Kaliganj, Dehghata and Shyamnagar Upazillas of Satkhira district, the most remote and poorest upazila of Bangladesh</td>
<td>To increase community awareness to prevent unwanted pregnancies and access to safe MR services</td>
<td>Nalta Hospital: pre-counselling, safe MR services, post-counselling - Government with service provider, managers and local DDFP for contraception and referral</td>
<td>Health educator - Shwadhikar - Shushamaj - IEC/BCC - Group sessions - Songs and dramas</td>
</tr>
<tr>
<td>MSCS</td>
<td>A mixture of all socioeconomic and areas hard to reach at Moulvibazar, Feni and Sherpur</td>
<td>To prevent unwanted pregnancies and utilization of safe and quality MR services in public-NGO-private service delivery facilities</td>
<td>Government with service provider, managers and local DDFP for referral</td>
<td>FCSG members, microcredit NGO workers, microcredit managers/supervisor and sensitized elected female representatives, female school/college teachers, key decision-makers, formal and informal leaders, gatekeepers to health and FP field workers - IEC/BCC - Group sessions</td>
</tr>
<tr>
<td>Phulki</td>
<td>Garment factory workers</td>
<td>To prevent unwanted pregnancies and enhance rights-based demand for safe MR services</td>
<td>MR/FP services are referred to the choice of government or NGO service provider</td>
<td>Master trainers’ groups and peer educators - IEC/BCC - Group sessions</td>
</tr>
</tbody>
</table>
| FPAB         | Women in mostly rural and remote areas | To improve equitable access to quality of MR services and increase awareness of community on right-based reproductive health issues | Government with service provider, managers and local DDFP for referral. | - Reproductive health promoter (RHPs)  
- IEC/BCC  
- Group session |
|-------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| BAPSA       | The poor and vulnerable women and men, Bhola district of Barisal | To prevent unwanted pregnancies by creating awareness for FP methods and prevention of unsafe MR through multi stakeholder partnership | MR/FP services are referred to the choice of government or NGO service provider | - Peer educators  
- Family planning workers (FWV/ FWA/HA)/ service providers  
- Micro credit NGOs, UP female members, female school and college teachers; key decision-makers, formal and informal leaders and gatekeepers  
- IEC/BCC  
- Folk songs, popular theatre and other cultural events  
- Community-level information centres (CICs) |
| ICCDR,B     | Underserved women in slum dwellings at Komolapur, tribal population at Mirersharai, coastal people at Shaymnagar | To describe the sociocultural aspects and women’s perception on MR and MR services, and explore providers’ perspectives on access and quality of care and services with regard to MR | N/A | N/A |
A mid-term review (MTR) of the project to strengthen the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh was held in Dhaka in November-December 2010. The review evaluated the progress in project implementation, the achievements made and the challenges experienced by different stakeholders.

This report of the mid-term review highlights findings and recommendations for the government and WHO. Recommendations were also made for the partners implementing projects funded by the Challenge Fund to further strengthen the menstrual regulation programme and related services in Bangladesh.