Organisation	Date	Reporting period
Embassy of the Kingdom of the Netherlands, Dhaka, Bangladesh	June 2016	2015

Activity		2015	Implemented by		Result area	Rio marker		Gender marker
Number	Name	Actual expenditure	Name organisation	Channel	Result area	Mitigation/Adaptation	Significant/principal	Significant/principal
21881	UBR: Unite for Body Rights	135.000	Family Planning Association of Bangladesh	NGO	Youth, information and choice	Not applicable	Not applicable	Significant
24595	Nirapod: Reducing Unwanted Pregnancy and Unsafe Menstrual Regulation	269.460	Marie Stopes Bangladesh (Lead) with 3 NG	NGO	Health commodities	Not applicable	Not applicable	Significant
24861	GB: Generation Breakthrough	1.801.324	UNFPA with Ministries of Women & Educat	Multilateral organisation	Youth, information and choice	Not applicable	Not applicable	Significant
25709	SHOKHI: Women's Health, Rights, and Choices	580.385	Bangladesh Leagl Aid and Services Trust (I	NGO	Rights and respect	Not applicable	Not applicable	Significant
26530	Working with Women (WwW): Promoting SRHR through Inclusive Business	771.631	SNV (lead)	NGO	Quality healthcare services	Not applicable	Not applicable	Significant
26547	Support to Health Sector Programme (HPNSDP) 2012 – 2016 through Multi	Continuation of the one of contribution of $ 5 million in 2014	World Bank, Ministry of Health and Family	Multilateral organisation	General	Not applicable	Not applicable	Significant
27085	IMAGE - Initiatives for Married Adolescent Girls' Empowerment	720.989	Terre des hommes, NL (lead), RedOrange	NGO	Youth, information and choice	Not applicable	Not applicable	Significant
21338	Sexual Reproductive Health	64.432	ICDDR,B	Research institute and companies	General	Not applicable	Not applicable	Significant
27827	RITU, promoting MHM	377.145	SIMAVI	NGO	General	Not applicable	Not applicable	Significant
27965	DHA-Empower Women on SRHR	300.398	Marie Stopes International	NGO	General	Not applicable	Not applicable	Significant
27977	DHA-Unite for Body Rights 2	700.000	RHSTEP	NGO	General	Not applicable	Not applicable	Significant

Result Area 1	Youth, information and choice
Result question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?	1a. According to Bangladesh Demographic Health Survey (BDHS) 2014, the use of contraception has increased slightly over the recent years. While previously there was a growth of 5% in 4 years (from 56% to 61% between 2007 and 2011), contraceptive use has increased only slightly with 1.4% between 2011 and 2014, from 61% to 62.4%. The use of contraception varies by age; among women, the use of any method increases with age, rising from usage among 51.2% of currently married women age 15-19 to a peak usage of 73.7% at age 30-34. Lower levels of use among younger women are usually attributed to their desire to have more children. After an initial growth of condom use among males of 15-19 years between 2007 and 2011 (4.1% to 6.8%), this percentage is only 6.2% in 2014. There is no data available for 2015 yet. 12.7% Bangladeshi women age 15-24 are knowledgeable about HIV/AIDS while the population average is 10.9%. Bangladesh has been implementing HIV prevention programs through awareness-raising activities since 1987. In 2014, 12.0% people of age 15-19 had correct and comprehensive knowledge about HIV/AIDS, while in 2011 that was 11.4% and in 2007 6.8%. Comprehensive knowledge of HIV/AIDS is higher among urban (17.5%) than rural (8.3%) women. 27.2 % Women who have completed higher secondary education have comprehensive knowledge while only 3.5% women with no education know about HIV/AIDS.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Results 2016	Source
Indicator 1: Percentage using condoms at last high-risk sex, by age group (MDG indicator 6.2)	Age 15-19: 4.1% (2007) M: F:	Age 15-49: 6.75% (2016); Age 15-19: no target	Age 15-19: 6.8% (2011)	Age 15-19: 6.8% (2011)	Age 15-19: 6.2% (2014)	Age 15-19: 6.2% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 2: Percentage of young people (15-24) with comprehensive correct knowledge of HIV/aids (MDG indicator 6.3)	Age 15-24: 12.95% (2007) M: 17.9% (2007) F: 8.0% (2007)	50% (15-49)(2016); Age15-24: no target	Age 15-24: 13.15% (2011); M: 14.4% F: 11.9%	Age 15-24: 13.15% (2011)	Age 15-24: 13.15% (2011) M: 14.4% F: 11.9%	Age 15-24: 12.7% (2014); 15-49: 10.9%		Bangladesh Demogarphic Health Survey (BDHS) 2014

Result question 1b: (1) With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school? **Result question 1b: (2) With which results have programmes contributed to opportunities for young people have their voice heard and stand up for their right?**	The number of adolescent/young people coverage has gone down last two years as we have closed five big programs namely –two in SRHR and Gender and three in Education. b1) The Unite for Body Rights (UBR) programme has introduced the CSE curriculum 'Me and My World (MMW)' in Bangladesh. A web based as well as a paper version exists and there are mobile applications and leaflets available as well as a website, all in the Bangla language. The UBR programme has effectively involved volunteers (Youth Organizers) from the 72 communities in facilitating MMW sessions and implemented the MMW program in 72 schools/colleges/madrashas & Youth Centers of 12 UBR Upazillas in 10 districts. In each school/madrasha two teachers (1 Male, 1 Female) are trained and 3086 students have completed the programme. The Generation Breakthrough (GB) project worked in 300 schools and 50 Madrashas in 4 districts. They will start its school based intervention from 2016, which will cover 350 schools and 500 madrashas in four districts of the country. . The Gender Equity Movement in Schools (GEMS) curriculum has been introduced to the teachers. The SHOKHI project is reaching young people in fifteen urban slums in Dhaka city both through its community mobilization interventions as well as its direct health, legal and information services delivery. During the reporting period, SHOKHI health facilitators provided sexual and reproductive health related information to 170 young people. In addition, 280 young women and girls received sexual and reproductive health information and services including on menstrual hygiene management, RTI and STI and contraceptives. The Nirapod project organized various sessions on Adolescent SRHR issues in 184 schools and 228 public facilities at union, Upazilla (sub-district) and district level. These sessions aware young people on reproductive health services, menstrual hygiene, Violence against Women, sexual harassment and early marriage and promote equal gender relations among young people. Nirapod has managed to educate a total of 35,673 adolescents by 420 trained Community Adolescent Group (CAG) members/peer educators. Nirapod also trained 555 school and madrasa teachers on ASRHR issues and a total of 18,464 students received project related information from these teachers in 2015. b 2) Peer education in schools and Madrasa's is organized by 3 SRHR projects i.e. UBR, Nirapod and GB. It helps adolescents developing their opinions. Besides, these projects are engaging adolescents in various national and international day observances, community based creative fairs, campaign programs and essay/debate competitions which helped raising the voice of young people and standing up for their rights. To strengthen the participation of youth in decision-making processes and to increase their impact on local development, the UBR project initiated to train 24 Youth Organizers, 2 from each of the 12 upazillas, on leadership that helps to enhance their life skills, communication skills, working with different stakeholders and advocacy skills. It was a comprehensive training with a lot of practical insights to develop the self-confidence and strength of young girls. UBR started a pilot program in 2015 named "Self-defense for young girls". Karate techniques and exercises to help the girls to increase their physical & psychological capacity to face uneven situations are offered to 20 young girls of two upazillas. Generation Breakthrough provided information on Gender Based Violence prevention and ASRHR through club-based interventions to 450 adolescents who are out of school and aged 13-18. In 2015 total 19,252 adolescents received in this way information on sexuality, STI, pregnancy and contraceptives. GB is working in partnership with community level sports clubs and involving other favored extracurricular activities which are envisaged to enable the project to reach out to additional adolescent boys aged 15-19 years. Through its helpline a counselling service facility for adolescents started in 2015. The project has successfully counselled 2,606 boys and 379 girls till now. BBC radio provided 49 radio airings for adolescent listeners. These could send feedback and questions and each 10th airing was spent on answering their questions. IMAGE has reached its key target of 4,415 early married girls, who were married before the age of 18, their husbands, in laws and interested youths through trainings, awareness events, promoting change-makers along with leadership trainings. Day to day household visits and briefing sessions on SRHR created awareness among young married girls in the working areas regarding possible choices and healthy practices. 180 Change-makers including 90 early married girls and 90 unmarried adolescents / youths both male and female were identified and provided with training on active citizenship and leadership. Given the platform, they learned about their rights which are contributory to their own developments; at the same time they became confident and vocal to make their voices heard by the community. The Gender and psychosocial lessons conducted by the SSCOPE project in 33 schools in 9 different slums empowered 1,625 underprivileged students. Methods were dialogue, story-telling and art centric mediums. Some of the topics that were covered were body image, self-expression, gender roles, and nutrition during growing up, relationship with family and friends, abuse, power inside the classroom, anger and stress management and animal abuse. Day to day household visits kept students in school, prevented child marriages and solved conflicts between students and parents.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number (or %) of youth-friendly (health + safe space) centres	9,347 (2011)	843	6.480	332	126	460		Annual reports of UBR, GB, Nirapod, and SSCOPE programmes
Indicator 2: Number of youth (10-24) using sexual and reproductive health services by organisation supported	0 (2011)	750.000	244.298	574.366	338.117	296491		Annual reports of UBR, GB, Nirapod, SHOKHI and SSCOPE programmes
Indicator 3: Number of schools that adopt comprehensive sexuality education	451 (2011)	963	700	278	291	527		Annual reports of UBR, Nirapod, and SSCOPE programmes
Indicator 4: Number of youth (10-24) in school & out of school reached with information on sexuality, HIV, STIs, pregnancy, contraceptives	250 (2011)	191.450	347.824	76.591	145.550	268353		Annual reports of UBR, GB, Nirapod, SHOKHI, SSCOPE, and IMAGE programmes
Indicator 5: Number of actions/protests taken by students for reducing sexual harassment	0 (2011)	no target	411	100	61	18		Annual reports of SSCOPE programme
Indicator 6: Number of schools where students could raise their voice and stand up for their rights	0 (2011)	700	586	350	449	527		Annual reports of UBR, Nirapod and SSCOPE programmes
Indicator 7: Number (and %) of teenage girls (<20) that are pregnant or have a child		n/a				1317		Annual reports of UBR, Nirapod, and IMAGE
Indicator 8: Number of schools with HIV/Aids education								
Indicator 9: Pupils and teachers with changed attitudes as well as improved knowledge and skills for protection against HIV/STI transmission and unwanted pregnancies								
Indicator 10: Children and young people demonstrate positive behavioural change on SRHR								

Assessment of results achieved by NL across the entire Result Area 1	Youth, information and choice
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	1. Results were achieved as per plan due to a combination of interventions including community mobilization working on the demand side and direct health service delivery working to support the supply side; 2. Holistic approach in the projects-target groups include adolescent boys, girls, teachers, parents, community leaders, religious leaders, ready-made garment workers, factory managements, Local NGOs, networks, local government representatives and relevant ministries at the central level; 3. Schools, where teachers are trained became the integral part for the information dissemination what brought more tangible results; 4. Increasing knowledge and counseling skills of service providers from government and non-government service centres realized Adolescent Friendly Health Services with a focus on SRH rights of adolescents; 5. Technical assistance and training at all levels of managers, health providers, teachers and students in selected schools/colleges/madrashas by the projects; 6. Effective use of media i.e. community radio, FM radio, helplines, theatres (TfD), picture pot songs, fairs, talent competitions etc.; 7. Most importantly active participation of adolescents and youth in the cycle of the project through knowledge sharing on their rights and practicing these rights. Youth organizers/Change-makers idea and process play a significant role in the progress of activities.
Implications for planning:	Child marriage remains to be one of the priority issues in almost all the programmes. In 2016 accelerated implementation of interventions in the schools/colleges/madrashas of UBR 2, GB, Nirapod-2 and Ritu projects will be carried out to achieve more results in reaching adolescents, irrespective of their gender, marital and financial status, with SRHR messages. The Media, as partner of all programmes, plays an important role in awareness raising, knowledge development and advocacy. The IMAGE project continues to create an enabling environment for young married girls to support their release out of isolation. Partners continue perusing the Network on child marriage- the 'Girls Not Bride' in realizing the national target of achieving the end of child marriage under 15 in Bangladesh by 2021. UBR-2 will focus its activities to include HIV/AIDS, gender and counseling in its SRHR issues. All the students and teachers will be training the MMW curriculum and relevant advocacy activities will be accelerated. The SHOKHI project will continue providing SRHR services and information through the Hubs to the selected people in 15 slums people, especially women. With the approval of medical MR by the government Nirapod-2 will strengthen its activities related to the provision of information, dissemination and more and better access to MRM. SRHR programmes will provide more emphasis on working together, sharing learning and joining hands in advocating toward policy changes and implementation at the national level. Youth involvement in the community mobilization model through change-makers, to create and maintain a body of knowledge and information within the communities, addressing sustainability of the programmes will continue to be a focus of the programmes. All programmes will continue involving local government, NGOs, schools and community/religious leaders in their activities to take over successful programmes. Help line numbers will be promoted throughout the year among the adolescents and youth for ensuring wider access to information. Ritu will start its implementation in primary and secondary schools on menstrual hygiene management (MHM) working together with the UBR 2 programme to create enhanced impact in the lives of the girls with the supply of information and bio-degradable sanitary napkins developed in country with technical support of TNO, NL. As adolescents are more vulnerable to unwanted pregnancy and unsafe MR due to limited access to information and services, the projects will continue to focus on bridging these knowledge gaps, particularly on safe MR (right time, right place and right service provider) and the use of contraceptives. Coverage will be scaled up by initiating and nurturing more adolescent/youth clubs/centres in the project areas of UBR 2, Nirapod 2 and IMAGE.

Result Area 2	Health commodities
Result question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?	Overall, 62.4% of the currently married Bangladeshi women age 15-49 (as mentioned in the BDHS, but actually it is about married couples) are using a contraceptive method. More than half (54.1%) of the married couples use a modern method, and 8.3% use a traditional method. The pill is by far the most widely used method (27%), followed by injectables (12.4%), male condoms (only 6.4%), and female sterilization (4.6%). Intra-uterine devices are used by only 0.6%, and male sterilization only by 1.2%. According to available data, during 4 years between 2011 and 2014, the modern contraceptive prevalence rate of Bangladesh has only increased 2% to 54.1% (BDHS 2014). The use of condoms by male 15-49 age group has increased with less than 1% only in 4 years- from 5.5% in 2011 to 6.4% in 2014. The contraceptive use continues to be higher in urban (65.9%) than in rural areas (61.1%), although the gap has narrowed from 62% and 54% respectively. There are some urban-rural differences in contraceptive use. For example, the use of condoms is more popular in urban areas (11.7% urban versus 4.4% rural) whereas the use of injectables is higher in rural areas (13.5% rural versus 9.8% urban). There is little variation in overall contraceptive use by economic status of women, with 62.7% contraceptive use in the least wealthy quintile and 63.3% in the most wealthy quintile (BDHS 2014). There is, however, a difference in methods, with progressively higher condom use per higher wealth quintile, 1.3 and 15.4 respectively, and progressively lower injectable use per wealth quintile, 17.9 and 6.7 respectively. Girls age 15-19 who use modern contraceptive methods increased since 2011 and is now 46.7%. In 2011 it was 42.4%. Overall, 12% of currently married women have an unmet need for family planning services (5.3% for spacing and 6.6% for limiting births). The total demand for family planning is 74.4% (BDHS 2014). Unmet need for family planning decreases with increasing age, ranging from 17.1% among women age 15-19 to 7.0% among women age 45-49. Women in rural areas have a higher unmet need (12.9%) than women in urban areas (9.6%). By division, unmet need is highest in Sylhet (17.7%) and lowest in Rangpur (6.7%). The unmet need for the lowest wealth quintile is 13.1% and is less for the highest wealth quintile (11.3%). The Health Population and Nutrition Sector Development Programme (HPNSDP) 2011-2016 results-framework has set a target to reduce unmet need for family planning services to 9% by 2016 (BDHS 2014). The government is catering to around half of all users (48.7%) of contraceptive methods of which GoB fieldworkers (FWAs) supply 20%. The private sector provides contraceptives to 43% of all users, with pharmacies supplying 38%. About 38% of pill users and 60% of condom users use a socially marketed brand. Non-governmental organizations (NGOs) supply contraceptives to 4.4% of users. According to the government data, less than 1% of the population is infected with HIV/AIDS. Almost all who are diagnosed are treated and provided with the anti-retroviral drugs. For HIV/AIDS, the major health provider is the public sector (BDHS 2014). Bangladesh remains a low HIV prevalence country with less than 0.1% overall prevalence in general population over the years. The HIV prevalence remains less than 1%. Till date, the country has registered a total of 3674 cases of HIV infection. However, the estimated number of people living with HIV is around 9500. Although the prevalence remains low, Bangladesh is one of the only four countries in Asia and the Pacific where prevalence has increased more than 25% over a decade till 2012 (GARPR, Annual Progress Report Bangladesh 2015) Most of the HIV programmes for the last decades have been focused on HIV prevention. In 2005 an antiretroviral therapy (ART) programme was started in NGO settings in a small scale. Under the Global Fund Round 6 projects, the Ministry of Health and Family Welfare (MOHFW)/National AIDS/STD Programme (NASP) as Principal Recipient (PR) and Save the Children as Management Agency (MA) initiated the ART programme for People living with HIV/AIDS (PLHIV). (Antiretroviral Therapy Programme in Bangladesh: Increasing National Ownership, 2013). The program to limit the spread of HIV infection among the most at risk populations increases its scale over time and is now covering 57% of the total people who inject drugs (PWID) and 39% of total female sex workers (FSW) according to the national size estimation, 2009. Seven hundred PLHIV (men, women and children) are receiving treatment (ART), care & support for their survival and to lead a quality life (Save the Children Bangladesh: HIV and AIDS).

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Contraceptive Prevalence Rate - modern methods- all married women 15-49 in developing regions	47.5% (2007)	72% (HPNSDP target for 2016)	52.1% (2011)	52.1% (2011)	54.1% (2014)	54.1% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 2: Contraceptive Prevalence Rate - modern methods- all girls 15-19	37.6% (2007)	No target for this age specific	42.4% (2011)	42.4% (2011)	46.7% (2014)	46.7% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 3: Unmet need for family planning of married women 15-49 years old	17.1% (2007)	9% (2016)	13.5% (2011)	13.5% (2011)	12,0% (2014)	12,0% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 4: Unmet need for family planning of girls 15-19 years old	19.4% (2007)	No target for this age specific	17% (2011)	Overcoming the barriers and with knowle17% (2011)	17% (2014)	17% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 5: Unmet need for family planning of 20% poorest	17.4% (2007)	No target for this specific quintile	13.8% (2011)	-		13.1% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 6: Unmet need for family planning of 20% richest	15.6% (2007)	9% (by 2016)	12.6% (2011)	-		11.3% (2014)		Bangladesh Demogarphic Health Survey (BDHS) 2014
Indicator 7: Number of couples protected by various contraceptives (= Couple Year Protection (CYP)	NA	23.9 million (by 2016)	21.2 million	21.6 million		23.0 million		NIPORT, Family Planning Commodity Projection for 2014-2021
Indicator 8: Proportion and number of the access to antiretroviral therapy of people living with HIV (MDG indicator 6.5), in developing regions	90% (2009)	100%	100% (2011)	91% (2012)		700 ART of estimated 9500 (PLHIV) (2009)		Global AIDS Response Progress Report (GARPR), Annual Report 2015

Result question 2b: (1) With which results have programmes contributed to a greater choice in and sufficient availability of contraceptives/medicines? **Result question 2b: (2) With which results have sociocultural barriers preventing women from using contraceptives been addressed?**	To ensure delivery of sufficient availability of contraceptives and proper information, the Nirapod, UBR, SHOKHI, IMAGE, Working with Women projects provided training to the service providers of clinic & field level workers. The SHOKHI project obtained contraceptives from the government and distributed these to community members through the health services provided at the hubs, one-stop centres. The contraceptives provided included male condoms and oral contraceptives. In the IMAGE project, 92% of the initial more than 4500 early married girls, spouses and in-laws have received sensitization training and information about different methods of contraceptives, available commodities and menstrual hygiene management products. The demand for all these products has been reportably increased and 10% increase of husbands using condoms has been measured. The Nirapod project has used a referral system to the GoB hospitals at district, Upazilla (semi district), municipality and Community Clinics, where community support group members (CSGs), NGOs and teachers referred community members to requiring services. This has become successful due to strong coordination and rapport with government service providers in the neighborhoods. Nirapod facilitated referral fees for CSG members. They get 1000 Taka plus a lunghi or a shari from the GoB if they refer someone for long acting and permanent methods, creating an opportunity of some income for them. Referral slips are retained in order to track the number of service intake. Nirapod's Referral Performance from January to December 2015 is 26,448. UBR Partners through the 12 NGO clinics which are well equipped with necessary equipment, facilities, medicines and human resources and very easy accessible for youths are providing SRHR services including contraceptives and sanitary napkins. Also from the Health-Camp provision young people are getting information and knowledge on SRHR issues including contraceptives. It helped to play a major role for breaking the social taboo. The Working with Women project partners obtained contraceptives, such as oral pill, condom, injectables and emergency contraceptive pills, from the government. The NGO's distribute these to Ready Made Garment workers and a total of 241 cycles of oral pills, 2.232 male condoms and 54 Injectables were distributed in 2015. To ensure delivery of proper information regarding contraceptives, the involved NGO's provide orientation to the RMG workers at the factory premises. Sessions on menstrual hygiene in the UBR project effectively introduced sanitary napkins to young girls. These are distributed in youth centres and at schools/colleges/madrashas. It is difficult to get females to spend money for their sexual and reproductive health and hygiene care found also WwW and Nirapod. By receiving sanitary napkins at low cost from the projects they are becoming habituated and recognizing the effect on their health and mobility. In this way RMG workers became motivated to buy napkins from the market. Menstrual Regulation (MR) with medication (MRM) which is a non-invasive method to terminate pregnancy is becoming popular in the country. MR through manual vacuum aspiration (MVA) continues to be provided by public, private and NGO facilities as usual and the UBR and Nirapod projects promoted a choice for their clients. To ensure the quality of MR/MRM services 15 senior nurses in 6 district hospitals were trained on MR/MRM, FP and PAC in the Nirapod project. And UBR trained 24 service providers from 12 upazillas on key concepts of MRM services and women's rights. In the Bangladesh society sociocultural norms and religious beliefs influence people's reproductive health (RH) choices. Women's lack of autonomy, lack of decision-making power, physical mobility and access to materials/ resources to seek family planning services are barriers for her SRHR. Male participation in reproductive health issues has always remained at a low level. In a male dominated society like Bangladesh, the issues of the use of family planning, Menstrual Hygiene Management (MHM), safe menstrual regulation (MR) services and Adolescent Reproductive Health and violence against women (VAW) are dependent on the support of men as partners as well as decision makers. In addition, the involvement of men will accelerate the various activities that would be undertaken in creating demand for quality services through rights based approaches. Increased awareness among women about how to access quality services is not enough until they start practicing and exercising this approach. Male involvement: The Nirapod project formed 42 Male Community Support Groups (MCSG) of 10 members each, and developed the men's capacity on family planning, Menstrual Hygiene Management (MHM), safe menstrual regulation (MR) services. The MCSGs involved male union parishod (UP) members and chairmen, formal and informal community leaders and all other stakeholders. All resulted in a more supportive role to women and encouragement to men to share their problems. Early married girls have to deliver a child: Through 292 sensitization trainings to 8,760 family members including mother in laws and unmarried adolescent girls, 148 sensitization trainings with 3,832 spouses, 90 civil society members and 180 change makers, the IMAGE project informed about the risks and potential negative effects of delivery by a child, promoted delay in 1st pregnancy up to the age of 20 and birth spacing for at least 3 years. Family Clubs, Spouse Forums, Change makers groups and Civil Society Forums worked together to create an enabling environment for early married girls to provide them the suitable contraceptive methods and services as well as encouraged cooperation and involvement of the husbands into the decision making process. Misconceptions regarding menstruation: the SHOKHI project includes awareness raising group sessions with young community members and theater for development to discuss menstrual hygiene and the use of sanitary napkins resulted in an increased uptake of napkins. Young people are not expected to be sexually active: Different kinds of activities in different tiers of the UBR project make the program familiar to mass people as well as religious leaders. It disseminated information messages in various gathering places where interaction of the people increased the acceptance of SRHR. To minimize the socio-cultural barriers UBR partners organized sessions on FP and SRHR in educational institutes, also madrasas, communities & youth centres. They renovated their clinics as UBR youth friendly centres (YFS), so that access to contraceptives to young people highly increased. In addition, knowledge dissemination on sexual reproductive health also happened through community advocacy meetings, parents meetings in school and UBR youth centres, health camps, courtyard meetings, observation of different days and events. To increase availability to contraceptives for young unmarried people, UBR provided contraceptives regardless marital status or registration. This made youth from passive seekers active users. RMG management doesn't want to invest in workers: To encourage management investment the Working with Women project arranged six cooperation between RMG factories and NGO-partners to improve female workers' SRHR. The NGO partners organized satellite sessions on FP and SRHR in factories premises and the contraceptive consumption of garments women highly increased. 5,456 workers, 90% female, were sensitized on FP, MR, MHM, STI/RTI, Health Insurance and VAW. As a result, 144 STI/RTI cases were both treated in six clinics/hospitals managed by the partners. RMG managements are very much interested and willing to continue activities if return of investment are proofed.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number and type of new, user-friendly products / medicines on the market for improved sexual and reproductive health	NA	NA	-	1	none	sanitary napkins - 1) handmade, disposable & reusable 2) low cost commercial for garment factory girls/women		Annual reports of UBR and WwW programmes
Indicator 2: Number of couples protected by various contraceptives (Couple Year Protection = CYP)	0 (2011)	60.000	59.034	46.946	1.609.681	1413995		Annual reports of UBR, Nirapod, SHOKHI, and WwW projgrammes
Indicator 3: Number of male and female condoms distributed	male: 0 (2011) female: n/a	male: 1,200,000 female:	male: 4198 female:	male: 1,121,251 female:	male: 1,350,970 female:	Male: 1.131.194 Female: n/a		Annual reports UBR, Nirapod, SHOKHI, and WwW programmes
Indicator 4: Number of married/unmarried men and women attending group sessions about the use of contraceptions	0 (2010)	934.410	80.913	198.174		545533		Annual reports of UBR, Nirapod, IMAGE, SHOKHI, and WwW programmes
Indicator 5: Number of community/religious leaders attending group sessions about the use of contraceptions	0 (2010)	5.425	1.268	2.420		712		Annual reports of UBR, Nirapod, IMAGE, SHOKHI and GB programmes
Indicator 6: Number of Adolescents, garment workers, micro-credit organizers informed about MR, FP, VAW, early marriage and use of contraceptions	0 (2012)	350.000	27.710	70.809		263830		Annual reports of UBR, Nirapod, IMAGE, SHOKHI,and WwW programmes

Assessment of results achieved by NL across the entire Result Area 2	Health commodities
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	1. In Bangladesh, the government health services are the sole source of contraceptives. Many NGO's, partners in the Nirapod, UBR, Working with Women projects, provided knowledge and services on contraceptives, menstrual hygiene management, HIV/AIDs and Menstrual Regulation. The strategy of providing contraceptives at the doorstep, through Youth centres, NGO hospitals/clinics (Static), Satellite camps, at ready-made garments health centres and Health camps at community level and door to door services, is recognized as the key factor in the attainment of the remarkable success of family planning (FP) in Bangladesh. 2. Socio-cultural barriers affect the awareness and uptake of contraceptives. However, strategies are being identified both to address the issue at a social level such as through public awareness campaigns organized by projects' support groups members/Change Makers/Youth Organizers in the community and through counselling individuals on a case by case basis; 3. Awareness through communications material like IEC materials, TV Commercials, Video shows, quiz competitions, animation, theme songs, social gathering are powerful tools to influence communities, which ultimately support the access to SRHR services-both public and private/NGOs by the adolescents and youths; 4. Non-judgmental ways (eg. Not querying on marital status) of providing services by the NGO/private and public service providers due to capacity building training provided by the projects proved to be effective in increasing access to commodities and services on MR, MRM, long-term FP methods and other SRH services by both married and unmarried youths; 5. Working with local NGOs, journalists, community leaders especially religious leaders, school/college/madrasha teachers, local government representatives i.e. Department of Family Planning; Health, the upazilla and union level health facilities, the local government education offices etc. also has accelerated the results achievement of increasing uptake of services. 6. Introducing helplines by different projects bring change in attitude among the communities regarding access to commodities and services.
Implications for planning:	In Bangladesh, the government health services are the sole source of providing contraceptives to poor people. SRHR programmes will continue to work closely with the government as one of the focus activities in wider distributing of contraceptives, for referral services, sustainability and policy advocacy. All programmes will continue addressing socio cultural barriers and promoting young men's and women's use of contraceptives and permanent family planning methods. Activating, renovating and turning public facilities accessible by the community people especially the young people jointly initiated with government, local government and communities by Nirapod, UBR and IMAGE will be more focused. Increased awareness on women's right to choice and consent and to empower women to exercise their voice in other aspects of their daily lives will be continued. Along with WwW project all projects partners will continue to: i) conduct awareness raising activities for the target beneficiaries, ii) equip the existing public/NGO health facilities by providing necessary reproductive health commodities including contraceptives, iii) sensitize the management authorities of the RMG factories on SRHR service need for their workers (WwW and Nirapod), iv) prepare and distribute different BCC materials on reproductive health and family planning needs; v) assisting and capacity building of public health providers to provide enabling environment to provide quality services. Popularization of MR with Medication and MR will be focused added with distribution and orientation on the MRM Guidelines will be continued by Nirapod and UBR. Strengthen involvement of all kinds of media for accelerating results of projects will also continue to increase the adolescent and youth coverage.

Result Area 3	Quality healthcare services
Result question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector improved?	3a: In Bangladesh 79% of women with a birth in the three years preceding the survey (2014) received antenatal care at least once from any provider (64% medically trained, 15% other), compared with 68% (55% medically trained, 13% other) in 2011. The urban-rural difference in antenatal care coverage is large: 89.3% of urban women received any antenatal care, compared with only 74.6% of rural women. The current health sector programme - Health, Population, and Nutrition Sector Development Programme (HPNSDP) 2011-2016 has targeted for 50% of pregnant women to make at least four antenatal care visits by 2016. This percentage is currently 31.2% (2014). The public sector remains the predominant source for providing sexual and reproductive health care. 37.4% of births in Bangladesh are delivered at a health facility: 12.8% in a public facility, 22.4% in a private facility, and 2.2% in an NGO facility. The sharp increase since 2011 (health facility birth percentage was 27%) has taken place primarily in private facilities. 62.2% of the births are delivered at home (BDHS 2014). Over the past ten years, the proportion of deliveries attended by medically-trained providers (qualified doctors, nurses, midwives, paramedics, or other Skilled Birth Attendants) has more than doubled, from 16% in 2004 to 21% to 42% in 2014. This can be attributed, at least in a part, to an increase in institutional deliveries. The HPNSDP 2011-2016 has targeted for 50% of the deliveries to be done by skilled providers by 2016. Between proportions of births attended by skilled health personal of the lowest and highest wealth quintile is a large difference: 10.9% and 63.7 % respectively. In 2014 the health budget was 4.6% of the total national budget. The declining trend that started from 6.2% in 2009-10 continues amid rising healthcare costs in Bangladesh. The per capita health spending, which is only $27 in Bangladesh, is the lowest in the region despite high malnutrition and mortality rates. The high private health expenditure, more than 60% of the costs are out of pocket, pushes 4 to 5 million people into poverty every year, while many fail to seek healthcare, according to the National Health Account 2011. This goes against the government's health financing strategy to raise the allocation for health to 15% by 2032 to ensure quality and affordable healthcare for all as the WHO has suggested.[Source: The Daily Star Issue of Friday, June 06, 2014: Health not well at all: Allocation falls well below WHO standards].

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Antenatal care coverage of at least one visit (MDG indicator 5.5)	60% (2007)	No specific target for one visit	68% (2011)	68% (2011)	80% (2014)	80% (2014)		BDHS 2014
Indicator 2: Antenatal care coverage of at least four visits (MDG indicator 5.5)	22.0% (2007)	50% (2016) (atleast four visits)	26% (2011)	26% (2011)	31% (2014)	31.2% (2014)		BDHS 2014
Indicator 3: Proportion of births attended by skilled health personnel (MDG indicator 5.2)	20.9% (2007)	50% (2016)	32% (2011)	32% (2011)	42% (2014)	42% (2014)		BDHS 2014
Indicator 4: Proportion of births attended by skilled health personnel of 20% poorest	4.8% (2007)	No specific target for 20% poorest	10% (2010)	11.5% (2011)	18% (2014)	18% (2014)		BDHS 2014
Indicator 5: Proportion of births attended by skilled health personnel of 20% richest						63.7 % (2014)		BDHS 2014
Indicator 6: Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV - low- and middle income countries						Not available		
Indicator 7: Percentage of government's budget allocated to health sector	6.2% of total budget (2009-10)	4.4% of total budget (2014-15)	5.1% of total budget (2011-12)	4.6% of total budget (2012-13)	4.7 % of national budget (2013-14)	5.3 % of national budget (2014-15)		Budget Special 2014-2015, The Daily Star, 6 June 2015

Result question 3b: (1) With which results has your programme contributed to improved cooperation between public and private healthcare services? **Result question 3b: (2) With which results has sexual and reproductive health care including emergency obstetric care become more affordable and accessible?**	3b 1. The Embassy's projects are working in cooperation with public health care services as well as tagging in with private/NGO facilities. As a result of the successful advocacy initiatives under the Nirapod project, the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare provided its consent to the project to establish 5 Menstrual Regulation corners in 5 general district hospitals which created more accessibility for MR services. To make the MR corners effective and sustainable 15 nurses received trainings on MR and PAC and these are coordinating the services in these corners. The Nirapod project conducted a participatory facility based needs assessments for each of the public facilities at the union level to assess the quality of care (safety, equity, access) as well as human resources (HR) capacity and maintenance of physical facilities (water, electricity) and decided on referral, renovation and provided small equipment as per need. In this way it ensured success in the supply side to meet the increased demand. The service delivery capacities improved also because of the training of public health providers in infection prevention. Of the 212 Unions within the Nirapod geographic areas 207 were supported. The remaining 5 unions had no public facilities available. This created much enthusiasm at community level for ownership of the health facilities, and the local governments demonstrated ownership by providing assistance for the construction of approach roads to the facilities. Outcomes of this facility improvement process are : i) increased flow of patients, ii) visible improved quality of service especially on infection prevention, iii) stronger coordination between community and service providers, iv) resource mobilization through increased ownership (community, government and others), v) sustained benefit of the project even after the end of the project period. The SHOKHI project has hubs where paramedics are providing basic health care services, free of cost, including maternal health services. The project entered into a referral relationship with 6 nearby NGO clinics to ensure provision of health services to the target slum population. Periodic meetings are conducted with these service providers to improve coordination and linkages. Also the SHOKHI project established referral/linkages with public hospitals. Improved cooperation between the 5 NGO's in the UBR project and public service providers made the public facilities more youth friendly. The project trained 418 public and NGO service providers on Youth Friendly Services (YFS), especially highlighting the counseling. The IMAGE project initiated collaboration with public facilities and trained health providers of the community and union health facilities in the working areas with a focus on specific needs of pregnant early married girls. The Working with Women project has renovated/equipped 6 health facilities in ready-made garment (RMG) factories. These, along with other 15 factory health centres are providing ANC and PNC services to targeted RMG workers. Referrals are utilized with three nearest hospital/clinics as external referral points. In this way 763 female and 169 male garment workers and 283 female, 31 male and 51 children from the communities received general health, SRH and childcare services. These initiatives aim to play a vital role for generating factories revenue to sustain the workers' healthcare in an inclusive manner. Different programs are using referral system but not all in a systematic way, hence they were not able to report. Since 2016 the programs plan to monitor and collect proper data on Referral. 3b 2. Accessibility: Projects like SHOKHI, Generation Breakthrough and SSCOPE organized a mapping on existing public/private/NGO health services in the surrounding areas, informed these about the project and referred their target groups to these service providers when needed. The Nirapod project renovated secondary or tertiary care hospitals/clinics focusing on in-patient and out-patient care to provide better SRH and general health services. In this way they made SRHR services more accessible. 4,413 clients received safe MR and FP and PAC services from these facilities 2015. UBR provided trainings to their own NGO service providers to create youth friendly services and environment. After these trainings, the providers are non-judgmental as well as committed to ensure confidentiality what made their services more accessible for youth. Affordable: The Nirapod project made services affordable to targeted project beneficiaries by providing these at reduced and subsidized price and free of cost medicine. The project also signed MoUs with pharmaceutical companies for sufficient and cheaper commodities and medicine. The community support group (CSG) members (female, male, adolescents) informed people on all FP methods to ensure choice and informed about other SRH services. 26,448 Clients were referred to get the right services from the right service providers free of cost. Referral slips were retained in order to track the number of services. Three WwW project partners are providing SRHR and other general health services to the female workers of the targeted factories through a health insurance scheme. 1,740 female workers are being covered under these insurance schemes and among them, a total of 606 female workers benefited last year. The service providers conducted orientation events to enroll the garment workers under the insurance scheme. The SHOKHI project provided sanitary napkins at a subsidized rate to adolescents in the project sites.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number of improved public facilities for Menstrual regulation (MR) services	0 (2012)	236	-	220	207	218		Annual reports of Nirapod , and UBR programmes
Indicator 2: Number of contacts (public/private/NGOs) for improved referal services	0 (2012)	8453	-	8260	653	249		Annual reports of Nirapod, UBR, SHOKHI and WwW programmes
Indicator 3: Number of safe MR/abortions	0 (2012)	3.700	1.807	3.060	3906	8315		Annual reports of Nirapod, UBR and WwW programmes
Indicator 4: Number of midwives/ skilled birth attendants trained		n/a				na		
Indicator 5: Number of health staff and community health workers trained in ante- and post natal care, safe deliveries and basic health care		1320+500				3054		Annual reports of Nirapod and UBR programmes
Indicator 6: Number of mothers receiving ante & post natal care		100000+500				78895		Annual reports of UBR and WwW programmes
Indicator 7: Access to basic emergency obstetric care (BeMOC) per 500,000 population		na				na		
Indicator 8: Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system at large		na				na		
Indicator 9: Percentage maternal health facilities with an increase in satisfaction by women		na				na		

Assessment of results achieved by NL across the entire Result Area 3	Quality healthcare services
Assess achieved results compared to planning:	A. Results achieved better than planned
Reasons for result achieved:	1. Programmes are continuing with the well-developed supportive/referral systems towards its activities by working closely with the local level public service providers which escalates the access to services by the target communities. 2. Wide sharing of information on existing available services including the partners' own NGO services i.e. SHOKHI Hubs, UBR YFS, WwW's Inclusive Business partners' health facilities around the garment factories etc. proved to be effective for increasing usage of services. 3. Programmes have established good relations with community leaders, public representatives, and media professionals, who are actively participating in different awareness programs like day observances, small events by the Change-makers, media campaigns, youth fairs, meetings with likeminded organizations; parents; Head teachers; religious leaders; also accelerates the service uptake and enthusiasm of service providers in rendering quality services. 4. The holistic approach, through public-private partnerships by training the public health providers, informing private providers like pharmacies, by physical improvement of the public facilities in the working areas, involvement of communities and local government.
Implications for planning:	Information on availability of health care services both within the community and in the surrounding areas helps community members to access necessary services as and when needed. SHOKHI will provide training to a number of change makers to serve as community health workers to sustain the changes introduced by the project. Information about Nutrition will be made available for the slum dwellers. Nirapod will strengthen the referral system to the public facilities for the MR and MR with Medication. The Inclusive Business (IB) models of the WwW project will continue providing better SRHR services to the women workers of the ready-made garment (RMG) factories. Ten Inclusive Business models will enhance the SRHR and empowerment of women labor force and showcase positive return of investments to the factory owners. The RITU project will create increased access to menstrual hygiene and the use of sanitary napkins by adolescents/young girls at union and upazilla level through working with schools and communities. The production of bio-degradable sanitary napkins in the county will be explored and production and distribution will be ensured through selected private pharmaceutical companies. The Embassy is working with other donors and the Ministry of Health and Family Welfare (MoHFW) of the Government of Bangladesh on the preparation of the next health sector plan 2017-2021. Also the Embassy and its SRHR partners are contributing in the revision of the Adolescent Health Strategy under the leadership of the Directorate of Family Planning, a wing of the Health Ministry. The aim is to incorporate issues of sexuality, sexual health, reproductive health of adolescents and youth, sexual rights, and adolescents' reproductive rights in the strategy and in the Action Plan. The Embassy's project partners will remain involved in the different Technical groups and consultations relevant to their projects.

Result Area 4	Rights and respect
Result question 4a: To what extent have the conditions for women, young people, sexual minorities, sex workers and intravenous drug users improved with regards to their sexual and reproductive rights?	4a: The legal age of marriage for women in Bangladesh is 18 years for men 21 years. A large proportion of marriages still take place before a woman reaches the legal age. The 2014 BDHS found that 59 percent of women age 20-24 were married before age 18. Between 2000 and 2011, the proportion who married before age 18 had hardly changed. But between 2011 and 2014 this proportion declined from 65 percent to 59 percent, the largest change ever observed between two BDHS surveys. According to the Human Rights Watch, Bangladesh had the fourth-highest rate in the world in 2013, after Niger, the Central African Republic, and Chad. Child marriage is associated with poor socio-economic status: 81% of the currently married women aged 20 till 24 are in the lowest wealth quintile while 56% are in the highest quintile. However it doesn't seem to be the only cause. Some of the key reasons for child marriage are related to gender inequality, tradition and insecurity. The young girls' opinions with regard to the marriage are often not taken into consideration. Within the national legal framework of Bangladesh, the Child Marriage Restraint Act, 1929 (CMRA) is the main law concerning child marriage and the obligations of persons involved to prevent child marriages. However, despite the stipulated punishments under the CMRA, penal sanctions for parents or guardians and those who solemnize an early marriage are so minor that they become irrelevant and that provisions addressing child marriage under national laws are routinely ignored and enforcement is virtually nonexistent. In July 2014, Prime-Minister Sheikh Hasina made a pledge to end child marriage under 15 in 2021 and for all in Bangladesh by 2041. Initiatives are taken to revise the current Child Marriage Law and to develop a National Plan of Action. Adolescent fertility in Bangladesh is still one of the highest in the world in 2014, with 113 births per 1,000 women between the ages of 15-19 (BDHS 2014). It is a serious cause of maternal and child mortality. The global average is 45 per 1000 women ages 15-19 (World Bank WDI 2013). The BDHS 2014 also shows that 57.8% of girls have begun childbearing by the age of 19. Unfortunately, misconceptions, stigma, discrimination and other human rights violations are still commonplace in Bangladesh and have a significant impact on the sexuality and sexual health of people. Often this is directed towards people who are sexually active outside a marital relationship, or to those who are pregnant and unmarried, those who are homo- or bisexual or transgender, as well as people with STIs or who have HIV (or are merely perceived to have it). As the concept of homosexuality is often viewed as incompatible with Islamic religious values and is a taboo for the semi-literate population, the society is largely homophobic. Practicing homosexuality is prohibited by the law under Section 377 A of the CrPC (Criminal Penal Code). The government has refused attempts at decriminalization and homophobia and violence against homosexuals remains rampant. The Hijra-community, consisting of transgenders, was provided with the right to vote in 2013 and was officially recognized as a third gender in that same year. Female Genital Mutilation is not an issue for Bangladesh.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Percentage of women married before age 18 in 20-24 year age group	66% (2007)	No marriage under 15 in 2021, no marriage under 18 in 2041	66% (2011)	64% (2013)	64% (2013)	59% in 20-24 years age group		BDHS 2014
Indicator 2: Percentage of female genital mutilation in 15-49 year age group						not available		

Result question 4b: (1) With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users and sex workers? **Result question 4b: (2) With which results has your programme contributed to improving the access of these specific groups to sexual and reproductive health services and commodities?**	4b1. Both, the Generation Breakthrough (GB) project as well as the Unite for Body Rights (UBR) project advocated successfully at the Ministry of Education and the National Curriculum and Textbook Board (NCTB) for the implementation of gender and equity and SRHR elements in the curriculum for secondary schools and madrashas and in the teachers training curriculum. Every four years the school textbooks are being revised and this is done without policy reform. The GB project managed to validate the GEMS curriculum by the Ministry of Education and adopted it in Bangla. One of the major barriers, the capacity lack of teachers, has been addressed. Teachers are trained on the curriculum to be able to implement it in GB schools/madrashas; The UBR project trained master trainers who trained teachers who do have comprehensive knowledge about SRHR and skills to deal with SRHR issues and thus are able to discuss sexuality issues with their young students. The five partners in the IMAGE project along with networks like Bangladesh Shishu Adhikar Forum (BSAF) with around 200 member organisations expressed solidarity and lobby for a Child Marriage Restraint Act without a special clause of the law which includes the possibility of a marriage of minor girls aged 16. During the Child Rights campaign week on 'Married still a Child' in 2015 IMAGE presented the consequences of being married while still a child. In the SHOKHI project advocacy is being continued to reform evidence collection procedures in rape cases and to improve survivors' access to justice. In 2013 and 2015 we calculated the community who has denounced child marriage and in 2014 we calculated the community/religious leaders with whom the programs had worked; so these were number of people, while in 2013/2015 are the number of communities. . 4b2. Through comprehensive sexuality education (CSE) in schools/madrashas, youth friendly service (YFS) clinics and youth clubs and centers, UBR partners provided information about many SRHR issues and offered young people the needed services and commodities. The IMAGE, Nirapod and SHOKHI projects also contributed to a better access of girls, women and youth to family planning commodities, sanitary napkins, SRHR information, etc. Generation Breakthrough is providing gender equitable relationship building education to adolescents and youth through school curriculum and community clubs providing them with the scope of getting to know themselves and thus being able to make informed choices on what is vital for them and develop a service seeking behavior. The involvement of parents, committees at upazilla and union level, the UNO (Upazilla Executive Officer) was important for an enabling environment and in this way youth representatives managed to get access to these committees and drew attention of UHFPO's (Upazilla Health and Family Planning Officer) to ensure Youth Friendly Services at Upazilla health complex level.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number of communities/local leaders that have denounced childmarriage	0 (2012)	1033		Childmarriage: 139	Childmarriage: 116,208	318		Annual reports of UBR, GB, Nirapod, SHOKHI, and IMAGE programmes
Indicator 2: Number of key populations having received sexual and reproductive health services and information								
Indicator 3: Number of changes in laws, legal guidelines leading to decrease of legal barriers for key populations in their sexual and reproductive health and rights								
Indicator 4: Perceived change in public statements made by leaders / personalities advocating for sexual and reproductive rights								
Indicator 5: Number of countries where health or health related policies changed to favor rights of vulnerable groups								
Indicator 6: Increased involvement of community leaders in realisation of SRHR in % of the targeted communities								
Indicator 7: Community members and community leaders participating in SRHR awareness-raising activities at community level								

Assessment of results achieved by NL across the entire Result Area 4	Rights and respect
Assess achieved results compared to planning:	C. Results achieved poorer than planned
Reasons for result achieved:	1. The Embassy's activities are targeting vulnerable groups like adolescents, youths, early married girls, RMG workers, slum dwellers an holistic approach proved to be making effective improvements in their lives; 2. Advocacy and awareness raising activities are impacting in attitudinal and behavioural change both at the community level and with local authorities, and at the national level with policy makers. Through national level advocacy initiatives, the provision of focused discussions and trainings law and policy changes could be facilitated where needed; 3. Cooperation and communication by donors, UN agencies and civil society caused delay of the new law on Child marriage, which is still with the Ministry of Law for approval. Partners and donors as well as the Girls Not Brides Network are working very closely at local level and at national level targeting to achieve a comprehensive positive revised Child Marriage Act without clause. 4. Media continues to be the means for youth to raise the issues of different sexual orientation topics.
Implications for planning:	Child marriage remains to be one of the priority issues for the Embassy as well as many donors. Knowledge sharing and action in almost all programmes will remain important in the future. In 2016 accelerated implementation of interventions in the schools/colleges/madrashas of the UBR 2, GB, Nirapod-2 and Ritu projects will be carried out to achieve more results in reaching adolescents, irrespective of their gender, marital and financial status. The Media, as partner of all programmes, plays an important role in awareness raising and knowledge development. IMAGE continues to create an enabling environment for young married girls to support their release out of isolation. Partners continue perusing the Network on child marriage- the 'Girls Not Bride' in realizing the national target of achieving to end child marriage under 15 in Bangladesh by 2021. UBR-2 will focus its activities to include HIV/AIDS in its SRH issues and in the students and teachers training curriculums and relevant advocacy activities will be accelerated. SHOKHI will continue providing SRH services and will add nutrition information through the Hubs to all people especially women in the selected 15 slums. With the approval of medical MR by the government Nirapod-2 will strengthen its activities related to the provision of information dissemination and more and better access to MRM also to adolescent girls. The Embassy's SRHR programmes will provide more emphasis on working together, sharing learning and joining hands in advocating towards policy changes and implementation. Youth involvement in the community mobilization models to create and maintain bodies of knowledge and information within the communities, addressing the sustainability aspect of the programmes will continue to be focus of the programmes. Affirmative legal or policy interventions are critical for supporting existing sexual health interventions or for introducing new ones. Laws and policies can also provide legal protection against any discrimination and stigma related to sexuality and sexual health status. Such legislation is fundamental to the creation and maintenance of a sexually healthy society and will get attention in a new programme for Adolescents Health.