Government of Canada
High Commission of Canada

Gouvernement du Canada
Haut-commissariat du Canada

March 28, 2011

United Nations Road,
Baridhara
Dhaka 1212

UNCLASSIFIED

Arthur Erken
UNFPA Representative
Bangladesh
United Nations Population Fund
IDB Bhaban (15th floor),
E/8-A Begum Rokeya Sharani
Sher-e-Banglanagar
Dhaka-1207

Dear Mr. Arthur Erken,

We are pleased to return to you, one of the two original copies of the signed Standard Administrative Arrangement between CIDA and UNFPA for the UN Joint Initiative "Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Expansion for six new districts."

We look forward to working with UNFPA, UNICEF, WHO and the Government of Bangladesh towards the goal of meeting the MDG 4 and 5 targets.

Sincerely,

Canada

Standard Administrative Arrangement
between
THE GOVERNMENT OF CANADA as represented by the Minister for International Cooperation, acting through the Canadian International Development Agency ("CIDA"),
and
THE UNITED NATIONS POPULATION FUND (UNFPA)

WHEREAS, Participating United Nations Organizations that have signed a Memorandum of Understanding (hereinafter referred to collectively as the "Participating UN Organizations") have developed a Joint Government of Bangladesh –United Nations Maternal and Neonatal Health Initiative (hereinafter referred to as the "Programme") starting on March 31, 2011 and ending on June 30, 2016, as may be amended from time to time, as part of their respective development cooperation with the Government of **Bangladesh**, as more fully described in the Terms of Reference of the Joint Programme Document (hereinafter referred to as the "TOR/Joint Programme Document"[1]), a copy of which is attached hereto as **ANNEX 1,** and have agreed to establish a coordination mechanism (hereinafter referred to as the "Steering Committee") [2] to facilitate the effective and efficient collaboration between the Participating UN Organizations and the host Government for the implementation of the Programme;

WHEREAS, the Participating UN Organizations have agreed that they should adopt a coordinated approach to collaboration with donors who wish to support the implementation of the Programme and have developed a TOR/Joint Programme Document to use as the basis for mobilising resources for the Programme, and have further agreed that they should offer donors the opportunity to contribute to the Programme and receive reports on the Programme through a single channel; and

WHEREAS, the Participating UN Organizations have appointed **the United Nations Population Fund (UNFPA)** (hereinafter referred to as the "Administrative Agent") (which is also a Participating UN Organisation in connection with the Programme)[3] in a Memorandum of Understanding (hereinafter referred to as "MoU") concluded between, the Administrative Agent and Participating UN Organizations on 27 March 2011, to serve as their administrative interface between donors and the Participating UN Organizations for these purposes. To that end the Administrative Agent has established a separate ledger account under its financial regulations and rules for the receipt and administration of the funds received from donors who wish to provide financial support to the Programme through the Administrative Agent (hereinafter referred to as the "Programme Account"); and

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[1] The Joint Programme Document contains at a minimum a common work plan, a budget, the coordination and management mechanism and signature of all participants. In the case of MDTF, the TOR will be used as base document for the establishment of the Fund.

[2] The composition of the Steering Committee or other body will include all the signatories to the Memorandum of Understanding, representative(s) from the host Government (if applicable), and may include donors, in accordance with UNDG approved Generic MDTF Steering Committee Terms of Reference dated 20 September 2007.

[3] In most cases, the Administrative Agent will also be a Participating UN Organization. However, where the Administrative Agent is not a Participating UN Organization, this provision can be deleted.

WHEREAS, CIDA (hereinafter referred to as the "Donor") wishes to provide financial support to the Programme on the basis of the TOR/Joint Programme Document as part of its development cooperation with the Government of **Bangladesh** and wishes to do so through the Administrative Agent as proposed by the Participating UN Organizations.

NOW, THEREFORE, the Donor and the Administrative Agent (hereinafter referred to collectively as the "Participants") hereby decide as follows:

Section I
Disbursement of Funds to the Administrative Agent and the Programme Account

1. The Donor decides to make a contribution of nineteen million seven hundred fifty thousand Canadian dollars (CDN $19,750,000.00) and such further amounts as it may decide (hereinafter referred to as the "Contribution") to support the Programme. The Contribution will enable the Participating UN Organizations to support the Programme in accordance with the TOR/Joint Programme Document, as amended from time to time in writing by the Steering Committee. The Donor authorizes the Administrative Agent to use the Contribution for the purposes of the Programme and in accordance with this Standard Administrative Arrangement (hereinafter referred to as "Arrangement"). The Donor acknowledges that the Contribution will be co-mingled with other contributions to the Programme Account and that it will not be separately identified or administered.

2. The Donor will deposit the Contribution by wire transfer, in accordance with the schedule of payments set out in **ANNEX 2** to this Arrangement, in convertible currencies of unrestricted use, to the following account:

UNFPA, Account No. 711442252204, at the Bank of America, 200 Front Street West, 26th Floor, Toronto, Ontario, Canada M5V3L2, Transit number: 56792, Bank key: 241

3. When making a transfer to the Administrative Agent, the Donor will notify the Administrative Agent's Treasury Operations of the following: (a) the amount transferred, (b) the value date of the transfer; and (c) that the transfer is from **CIDA** in respect of the Programme in **Bangladesh** pursuant to this Arrangement. The Administrative Agent will promptly acknowledge receipt of funds in writing.

4. All financial accounts and statements will be expressed in United States dollars.

5. The US dollar value of a contribution-payment, if made in currencies other than United States dollars, will be determined by applying the United Nations operational rate of exchange in effect on the date of receipt of the Contribution. The Administrative Agent will not absorb gains or losses on currency exchanges. Such amounts will increase or decrease the funds available for disbursements to Participating UN Organizations.

6. The Programme Account will be administered by the Administrative Agent in accordance with the regulations, rules, directives and procedures applicable to it, including those relating to interest. The Programme Account will be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the Administrative Agent.

7. The Administrative Agent will be entitled to allocate an administrative fee of one percent (1%) of the Contribution by the Donor, to cover the Administrative Agent's costs of performing the Administrative Agent's functions.

8. The Steering Committee may request any of the Participating UN Organizations, to perform additional tasks in support of the Programme not related to the Administrative Agent functions detailed in Section I, Paragraph 2 of the Memorandum of Understanding and subject to the availability of funds. In this case, costs for such tasks will be decided in advance and with the approval of the Steering Committee be charged to the Programme as direct costs.

Section II
Disbursement of Funds to the Participating UN Organizations and a Separate Ledger Account

1. The Administrative Agent will make disbursements from the Programme Account in accordance with instructions from the Steering Committee, in line with the approved programmatic document[4]/Joint Programme Document, as amended in writing from time to time by the Steering Committee. The disbursement to the Participating UN Organizations will consist of direct and indirect costs as set out in the Programme budget.

2. Each Participating UN Organization will establish a separate ledger account under its financial regulations and rules for the receipt and administration of the funds disbursed to it from the Programme Account. Each Participating UN Organization assumes full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. That separate ledger account will be administered by each Participating UN Organization in accordance with its own regulations, rules, directives and procedures, including those relating to interest. That separate ledger account will be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the Participating UN Organization.[5]

3. Where the balance in the Programme Account on the date of a scheduled disbursement is insufficient to make that disbursement, the Administrative Agent will consult with the Steering Committee and make a disbursement, if any, in accordance with the Steering Committee's instructions.

Section III
Implementation of the Programme

1. The implementation of the programmatic activities which the Donor assists in financing under this Arrangement will be the responsibility of the Participating UN Organizations and will be carried out by each Participating UN Organization in

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[4] As used in this document, an approved programmatic document refers to an annual work plan or a programme/project document, etc., which is approved by the Steering Committee for fund allocation purposes.

[5] Where the Administrative Agent is also a Participating UN Organization, it will need to open its own separate ledger account and transfer funds from the Programme Account to its separate ledger account.

accordance with its own applicable regulations, rules, policies and procedures including relating to procurement. The Donor will not be directly responsible or liable for the activities of any person employed by the Participating UN Organizations or the Administrative Agent as a result of this Arrangement,

2. The Participating UN Organizations will carry out the activities for which they are responsible, in line with the budget contained in the approved programmatic document/Joint Programme Document, as amended from time to time by the Steering Committee in accordance with the regulations, rules, directives and procedures applicable to it. Accordingly, personnel will be engaged and administered, equipment, supplies and services purchased, and contracts entered into in accordance with the provisions of such regulations, rules, directives and procedures.

3. Indirect costs of the Participating UN Organizations recovered through programme support costs will be 7%. In accordance with the UN General Assembly resolution 62/208 (2007 Triennial Comprehensive Policy Review principle of full cost recovery), all other costs incurred by each Participating UN Organization in carrying out the activities for which it is responsible under the Programme will be recovered as direct costs.

5. The Participating UN Organizations will commence and continue to conduct operations for the Programme activities only upon receipt of disbursements as instructed by the Steering Committee.

5. The Participating UN Organizations will not make any commitments above the budgeted amounts in approved programmatic document/Joint Programme Document, as amended from time to time by the Steering Committee.

6. If unforeseen expenditures arise, the Steering Committee will submit, through the Administrative Agent, a supplementary budget to the Donor showing the further financing that will be necessary. If no such further financing is available, the activities to be carried out under the approved programmatic document/Joint Programme Document may be reduced or, if necessary, terminated by the Participating UN Organizations. In no event will the Participating UN Organizations assume any liability in excess of the funds transferred from the Programme Account.

7. The Donor reserves the right to discontinue future contributions if reporting obligations are not met as set forth in this Arrangement; or if there are substantial deviations from agreed plans and budgets. If it is agreed among the Donor, the Administrative Agent and the concerned Participating UN Organization under the Arrangement that there is evidence of improper use of funds, the Participating UN Organization will use their best efforts, consistent with their regulations, rules, policies and procedures to recover any funds misused. The Participating UN Organization will, in consultation with the Steering Committee and the Administrative Agent, credit any funds so recovered to the Programme Account or agree with the Steering Committee to use these funds for a purpose mutually agreed upon. Before withholding future contributions or requesting recovery of funds and credit to the Programme Account, the Administrative Agent, the concerned Participating UN Organization and the Donor will consult with a view to promptly resolving the matter.

8. The Participants recognize that it is important to take all necessary precautions to avoid corrupt, fraudulent, collusive or coersive practices. To this end, as set out in the

MoU between the Administrative Agent and Participating UN Organizations regarding the Operational Aspects of the Joint Government of Bangladesh –United Nations Maternal and Neonatal Health Initiative, each Participating UN Organization will maintain standards of conduct that govern the performance of its staff, including the prohibition of corrupt, fraudulent, collusive or coersive practices in connection with the award and administration of contracts, grants, or other benefits, as set forth in their Staff Regulations and Rules and the Financial Regulations and Rules, including regarding procurement.

Section IV
Equipment and Supplies

On the termination or expiration of this Arrangement, the matter of ownership of equipment and supplies will be determined in accordance with the regulations, rules, directives and procedures applicable to such Participating UN Organization, including any agreement with the relevant host Government if applicable.

Section V
Reporting

1. The Administrative Agent will provide the Donor and the Steering Committee with the following statements and reports, based on submissions provided to the Administrative Agent by each Participating UN Organization prepared in accordance with the accounting and reporting procedures applicable to it, as set forth in the TOR/Joint Programme Document:

(a) Annual consolidated narrative progress reports, based on annual narrative progress reports received from Participating UN Organizations, to be provided no later than five months (31 May) after the end of the calendar year;

(b) Annual consolidated financial reports, based on annual financial statements and reports, to be received from the Participating UN Organizations, as of 31 December with respect to the funds disbursed to them from the Programme Account, to be provided no later than five months (31 May) after the end of the calendar year;

(c) Final consolidated narrative report, based on final narrative reports received from Participating UN Organizations after the completion of the activities in the approved programmatic document/Joint Programme Document and including the final year of the activities in the approved programmatic document/Joint Programme Document, to be provided no later than seven months (31 July) of the year following the financial closing of the Programme. The final consolidated narrative report will contain a summary of the results and achievements compared to the goals and objectives of the Programme.

(d) Final consolidated financial report, based on certified final financial statements and final financial reports received from Participating UN Organizations after the completion of the activities in the approved programmatic document/Joint Programme Document and including the

final year of the activities in the approved programmatic document/Joint Programme Document, to be provided no later than seven months (31 July) of the year following the financial closing of the Programme.

2. The Administrative Agent will provide the Donor, Steering Committee and Participating UN Organizations with the following reports on its activities as Administrative Agent:

(a) Certified annual financial statement ("Source and Use of Funds" as defined by UNDG guidelines) to be provided no later than five months (31 May) after the end of the calendar year; and

(b) Certified final financial statement ("Source and Use of Funds") to be provided no later than seven months (31 July) of the year following the financial closing of the Programme.

3. Consolidated reports and related documents will be posted on the websites of the Administrative Agent [Bangladesh.unfpa.org], as appropriate.

Section VI
Monitoring and Evaluation

1. Monitoring and evaluation of the Programme including, as necessary and appropriate, joint evaluation by the Participating UN Organizations, the Administrative Agent, the Donor, the host Government and other partners will be undertaken in accordance with the TOR/Joint Programme Document.

2. The Donor, the Administrative Agent and the Participating UN Organizations will hold annual consultations as appropriate to review the status of the Programme.

Section VII
Joint Communication

1. Information given to the press, to the beneficiaries of the Programme, all related publicity material, official notices, reports and publications, will acknowledge the role of the Government of Bangladesh, the donors, the Participating UN Organizations, the Administrative Agent and any other relevant entities.

2. The Administrative Agent in consultation with the Participating UN Organizations will ensure that decisions regarding the review and approval of the Programme as well as periodic reports on the progress of implementation of the Programme, associated external evaluations are posted, where appropriate, for public information on the websites of the UN in Bangladesh [www.un-bd.org] and the Administrative Agent [bangladesh.unfpa.org]. Such reports and documents may include Steering Committee approved programmes and programmes awaiting approval, fund level annual financial and progress reports and external evaluations, as appropriate.

Section VIII
Expiration, Modification and Termination

1. The Administrative Agent will notify the Donor when it has received notice from all Participating UN Organizations that the activities for which they are

responsible under the approved programmatic document/Joint Programme Document have been completed. The date of the last notification received from a Participating UN Organization will be deemed to be the date of expiration of this Arrangement, subject to the continuance in force of paragraph 4 below for the purposes therein stated.

2. This Arrangement may be modified only by written agreement between the Participants.

3. This Arrangement may be terminated by either Participant on thirty (30) days of a written notice to the other Participants, subject to the continuance in force of paragraph 4 below for the purpose therein stated.

4. Commitments assumed by the Donor and the Administrative Agent under this Arrangement will survive the expiration or termination of this Arrangement to the extent necessary to permit the orderly conclusion of activities, the withdrawal of personnel, funds and property, the settlement of accounts between the Participants hereto and the Participating UN Organizations and the settlement of contractual liabilities required in respect of any subcontractors, consultants or suppliers. Any balance remaining in the Programme Account or in the individual Participating UN Organizations' separate ledger accounts upon completion of the Programme will be used for a purpose mutually agreed upon or returned to the donor(s) in proportion to their contribution to the Programme as decided upon by the donor(s) and the Steering Committee.

Section IX
Notices

1. Any action required or permitted to be taken under this Arrangement may be taken on behalf of the Donor, by the Director, Bangladesh Program or his or her designated representative, and on behalf of the Administrative Agent, by the Resource Mobilization Specialist or his or her designated representative.

2. Any notice or request required or permitted to be given or made in this Arrangement will be in writing. Such notice or request will be deemed to be duly given or made when it will have been delivered by hand, mail, or any other agreed means of communication to the party to which it is required to be given or made, at such party's address specified below or at such other address as the party will have specified in writing to the party giving such notice or making such request.

For the Donor:

Name:	Peggy Thorpe
Title:	First Secretary (Development)
Address:	High Commission of Canada United Nations Rd, Baridhara, Dhaka 1212 Bangladesh
Telephone:	(8802) 988-7091-7, Ext. 3458
Facsimile:	(8802) 882-6585
Electronic mail:	peggy.thorpe@international.gc.ca

For the Administrative Agent:

Name:	Kae Ishikawa
Title:	Resource Mobilization Specialist

Address: United Nations Populations Fund (UNFPA)
220 East 42nd Street, New York, NY 10017

Telephone: 212-297-4950
Facsimile: 212-297-4918
Electronic mail: ishikawa@unfpa.org

Section X
Entry into Effect

This Arrangement will come into effect upon signature thereof by the Participants and will continue in effect until it is expired or terminated.

Section XI
Settlement of Disputes

1. Any dispute arising out of the Donor's Contribution to the Programme will be resolved amicably through dialogue among the Donor, the Administrative Agent and the concerned Participating UN Organization.

Section XII
Privileges and Immunities

1. Nothing in this Standard Administrative Arrangement will be deemed a waiver, express or implied, of any of the privileges and immunities of the United Nations, the Administrative Agent, or each Participating UN Organization.

IN WITNESS WHEREOF, the undersigned, being duly authorized by the respective Participants, have signed the present Arrangement in English in two copies.

For the Donor:

ANNEX 1: TOR/Joint Programme Document
ANNEX 2: Schedule of Payments

ANNEX 2

SCHEDULE OF PAYMENTS

Schedule of Payments:	Amount:
By March 31, 2011*	(CDN$ 4,000,000)
By March 31, 2012	(CDN$ 4,000,000)
By March 31, 2013	(CDN$ 4,000,000)
By March 31, 2014	(CDN$ 4,000,000)
By March 31, 2015	(CDN$ 3,750,000)

*The first payment will be made upon signing of this Arrangement. Subsequent payments will be made in accordance with the schedule upon receiving a payment request from the Administrative Agent, referring to the following CIDA financial coding:

Project #:	A-035190
P.O. #:	7056932
CC/GL:	4122/52304
Vendor #:	1003803

To Note: Out of $19,798,993 budgeted for the programme as per Annex 1-I, CIDA will contribute $19,750,000

Project Title	**Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Expansion for six new districts**
Country	Bangladesh
Submitting Organization	United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and World Health Organization (WHO)
Technical Implementing Agencies	United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and World Health Organization (WHO)
Funding Requirement	Total Estimated Cost of the Project for Five Years: CAD 19,798,993.00 (UN conversion rate: 1 CAD = 1.027 USD)

Arthur Erken
UNFPA Representative

Michel Saint-Lot
Deputy Representative
UNICEF, Bangladesh
Carel De Rooy
UNICEF Representative

Dr. Arun Bhadra Thapa
WHO Representative a.i

ANNEX A. EIGHT KEY RECOMMENDATIONS TO BE MET BEFORE EXPANSION

1. A package of evidence based interventions which save the lives of mothers and newborns be defined and adopted
2. Quality standards to support implementation of the basic package of interventions be defined (Benchmark 3)
3. A system of continuous quality improvement be put in place
4. The monitoring and evaluation position which is now vacant and a new position to support quality management is filled
5. There is strong medium term technical assistance support
6. The recent human resource report recommendations are acted upon and supported by international technical assistance
7. The emergency MNH drug inventory is undertaken
8. The selection and monitoring of facilities in the new districts be according to the latest UN guidelines and standards.

Annex B: October 2010 Review Final Presentation to Key Stakeholders (EC, DfID, MoHFW, UN-MNHI)

GoB UN Maternal and Neonatal Morbidity Reduction Initiative (MNHI)

Accelerating Progress towards
Maternal and Neonatal Mortality and Morbidity Reduction Initiative

Joint EC-DFID Review & Evaluation

End of Phase 1 (16th October –2nd November)

UKaid

European Union

Overview

1. Introduction and Progress
2. Issues
3. Management Recommendations
4. Recommendations for Improvement
5. Project's Future Course
6. Donor Recommendations

INTRODUCTION and PROGRESS

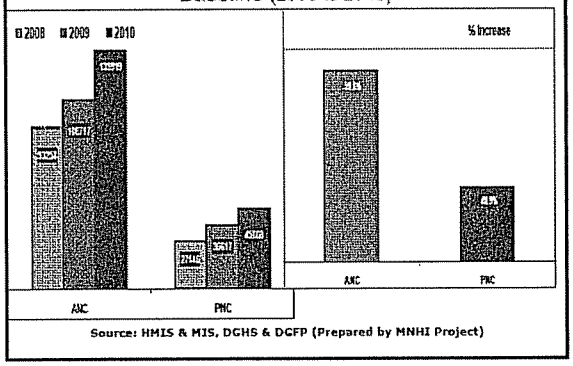
Introduction

- Now completed 19 months of actual implementation
- In the donors eyes MNHI has past 42 months duration
- Last review reported a significant improvement after a slow start
- Following this review donors will agree whether to commit to the scale up of activities in additional districts

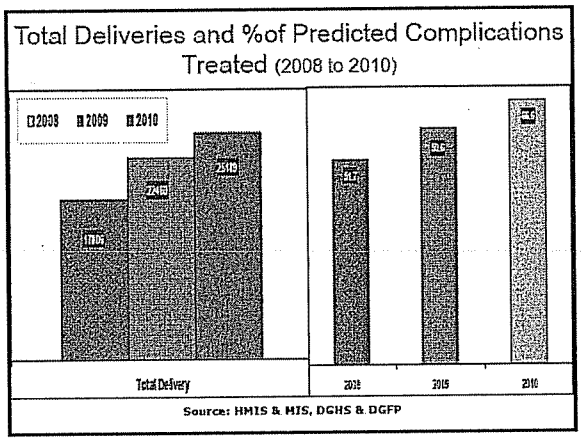
Progress

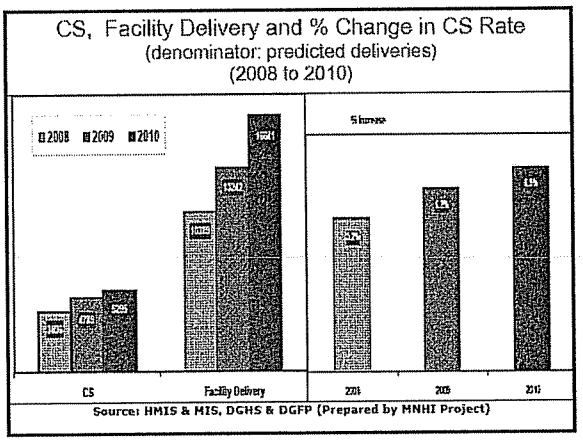
- Significant improvement across the board
- 2009 recommendations largely achieved (response to quality amazing)
- Most benchmarks have been met (staff positions to be filled)
- All 4 outputs broadly achieved (difficult to determine if activities under some outputs have been completed)
- Progress against log-frame indicators look convincing (large numbers, improvement in proxy indicators, but.. disaggregated data and qualitative evidence needed)

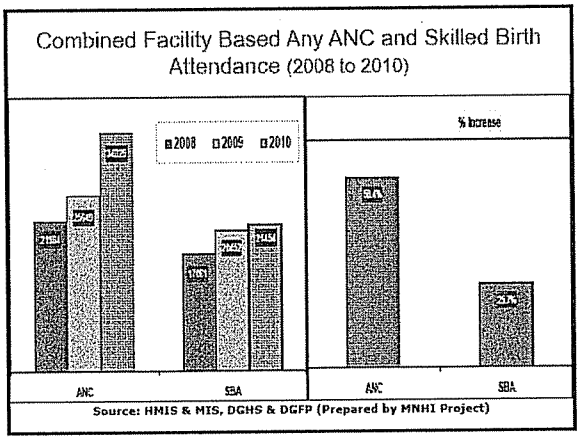
Any ANC and PNC Coverage and % Change from Baseline (2008 to 2010)

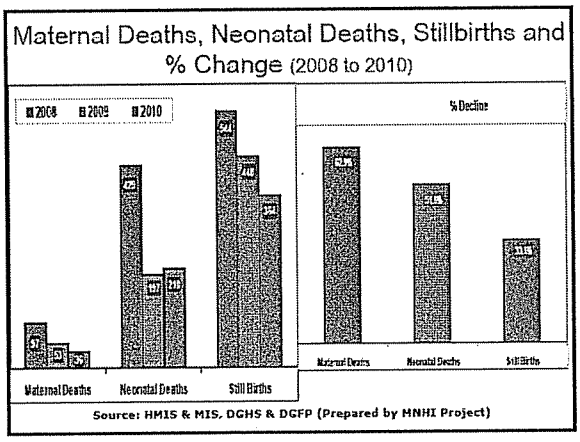


Source: HMIS & MIS, DGHS & DGFP (Prepared by MNHI Project)









Examples of Progress: Supply Side

- Sub-contracting of staff at district and Upzilla level (2 doctors, nurses, cleaners, guards)
- QA framework and standards linked to training, supervision and monitoring with professional association support
- Accreditation of WF District Hospitals (A further 2 in process)
- Monitoring of EmOC signal functions, AMSTL and infection monitoring introduced
- District Case Investment Analysis completed in 2 districts

Examples of Progress: Demand Side

- ComSS and initiatives like engagement in the Tea Gardens and establishment and renovation of estates clinics are to be applauded
- Voice and accountability: public forums, schools debates, district hospital information desks, comments box and exit interviews
- Development of a new cadre of community health volunteers – MoH FW is going to regionalise (issues with payment, FP needed in training)

Other Progress

- Evidence based interventions nearly ready for scale up:
  - Basic Health Worker Care
  - Neonatal Care
  - Emergency Triage and Treatment
  - Counselling in Antenatal Care and Post Natal Care
  - Essential Newborn Care counselling
- District Team Problem Solving (will add value to the district planning)
- Paid for Performance (nearing final evaluation)
- Maternal Perinatal Death Reviews (MPDR)

Integration in Next Health Sector Program

Too soon to say if MNHI has been integrated into the next sector program (under development). However;

- H4 Mission Report, draft sector strategy paper and pre-appraisal mission for next sector plan incorporates lessons from MNHI (district level plan with resource allocation, local HR recruitment, and focus on quality of care with equity)
- H4 has been officially requested to review and make inputs in the RH-MNCH component of the next sector program

Huge Potential

- Three strong UN institutions working together to influence policy and advocate for change
- A project that has been struggling to deliver is showing "real results"
- Results which could be scaled up rapidly

ISSUES

Issues

- There are serious concerns about the management
- Coordination between the three UN agencies and Project Office
- Results and evidence of the project need to be documented and widely disseminated.
- Donor visibility needs to be raised at the national level
- Parallel activities need to be absorbed into the health system

Issues

- Government system needs to be engaged more effectively to overcome bottlenecks e.g. approval of district plans
- Supervision and monitoring requires strengthening at all levels of service delivery
- A system needs to be in place to verify project results and data.
- The problem of long delays in implementing district plans will need to be addressed
- A sharper focus on the poor and marginalised is required

RECOMMENDATIONS FOR MANAGEMENT

Recommendations for Management

The lead agency (UNFPA) is moving the MNHI office to a new location with it's own identity.

- That the MNHI office be a central hub for technical assistance and supporting the coordination of project inputs and results.
- The project should work under one operational plan and the rules of the lead agency should apply for all levels of management (standardized management systems)

Recommendations for Management

- A project coordinator be appointed and a specialist consultant be engaged to provide regular backup. One of these persons should be a specialist in health systems strengthening and have a "track record" of working successfully with governments.
- The project team strengthened by having TA in at least the following areas QI, HR, FP and M&E/Research (? MNH). Positions should be internationally advertised and be open to national and international specialists. TAs will report directly to the project coordinator.

Recommendations for Management

- Full-time TAs should sit in the project office 100% of the time with a link to a specific agency and be supported by adequate operation staff
- Field officers are an extended arm of the MNHI office so will come under the rules of the lead management agency (with further expansion withdraw to regional level before phase out)
- Defer engagement of the DSF specialist until a firm decision is made about the implementation of DSF

RECOMMENDATIONS for IMPROVEMENT

Recommendations for Improvement

- Engage a private provider to support supervision, monitoring and development of clinical skills at a district level.
- Build accountability into the system; engage a private research or academic institution to verify results of the project and core data
- Undertake a high profile communication campaign to raise the visibility of MNHI at a national level

Recommendations for Improvement (continued)

- Instigate regular monitoring and evaluation visits to districts which involve the three UN agencies and (MoH&FW).
- To help address the delays in the planning cycle introduce a 2 or 3 year rolling plan
- When selecting communities to work with; target the poorest and hardest to reach
- ~~Clear guidelines need to be developed for identification of the poor.~~ (? Waiting for clarification)

Project's Future Course

Project's Future Course: Scale-Up

- The case for expansion is compelling
- Expansion implies **extension** and **TA support**
- Expansion will be faster than inception and should adapt a rolling model
- Phase 1 "MNHI" districts will be assets to new districts
- There is potential for significant management savings
- Will fit well with the duration of the next sector program

Recommendations: Scale-Up

The project has already considered 4 options for scale-up.

- Option 1: adjacent districts of existing 4 districts;
- Option 2: is based on indicators
- Option 3: coastal or hard to hard-to-reach districts.
- Option 4: 17 UNDAF districts (Geographical Targeting)

Wave 1

- To allow the sharing of assets between districts the review team proposes a scale-up to a minimum of 6 adjacent districts (option 1)

Recommendations: Scale-Up

- When agreeing on adjacent districts with the MoH & FW give priority to UNDAF Ranked Districts (Geographical Targeting)

Wave2

- Wave 2 consider having a minimum of 10 districts
- Future waves could follow and there could be an overlap between waves

Before Scale-Up

Agree on a package of high impact cost effective evidence based strategies and interventions that have been shown to work in a relatively short period of time. Consider where appropriate:

- Adequate number of skilled maternity and newborn health care providers available 24/7
- Improvement of infrastructure and maternity facilities
- Adequate and sustained supplies of maternal and newborn health commodities
- Improving management and monitoring including institutionalizing maternal and perinatal deaths review
- Reduction of barriers in accessing the services

Before Scale-Up

- Review the existing design, operational plan, structure and log-frame and come up with realistic and effective alternatives.
- Align with the existing health system to ensure institutionalisation of the interventions. Advocate for support through the MNH forum.
- Rationalise project management for cost effectiveness and efficiency; e.g. share resources between districts, consider contracting one NGO per district or one NGO to cover two districts, streamline baseline data collection and other studies through a single institution.

Before Scale-Up

- When selecting facilities consider geographical distribution of facilities according the MoH & FW EmOC coverage plan and the catchment areas around CHCs.
- Target the poorest and hardest to reach areas and the referral facilities from those areas.
- Consider developing a succinct acceleration toward MDGs 4 and 5 roadmap for Bangladesh which includes a table of interventions and evidence and implementation plan then have a high profile launch of the roadmap

RECOMMENDATIONS FOR DONOR SUPPORT

Donor Support

The review team believes that the project is on the verge of success. Technical assistance is needed to make it work. If existing donors wish to disengage with their current commitment:

- They should allow a reasonable time to phase out; allowing time for documenting of the lessons learned and best practices as a contribution to global knowledge. To have an optimum value for investment allow time for the implementation of the existing interventions under development.

Donor Support

- However; if a donor does disengage they will not capitalise on their investment which will be realised with the increased coverage of services ; i.e.
  - 885 additional mothers lives saved
  - 11,921 additional newborn lives saved

(Reference: Project Design Document)

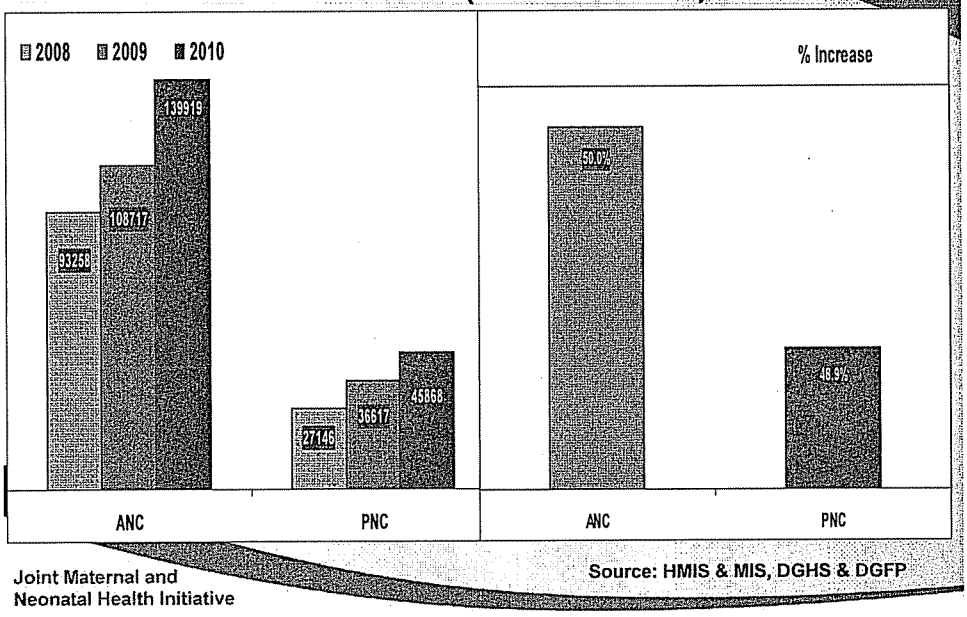
Thank-You

Jenny Middleton Dr Setara Rahman and Dr M.A Sabur

(EC/DFID Review Team 2010)

ANNEX-C: PROXY AND ACTUAL MNH OUTCOME INDICATORS

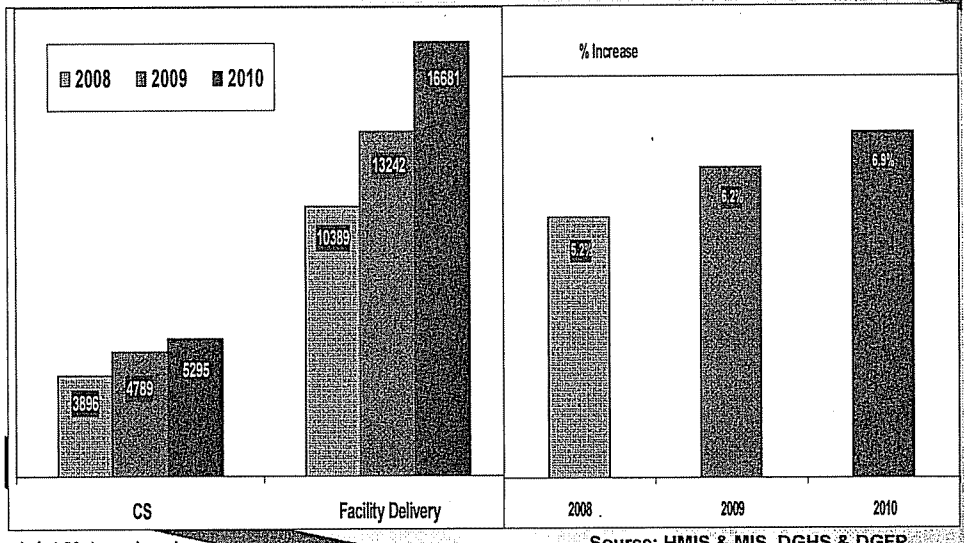
Any ANC and PNC coverage and Percent Change from Baseline (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

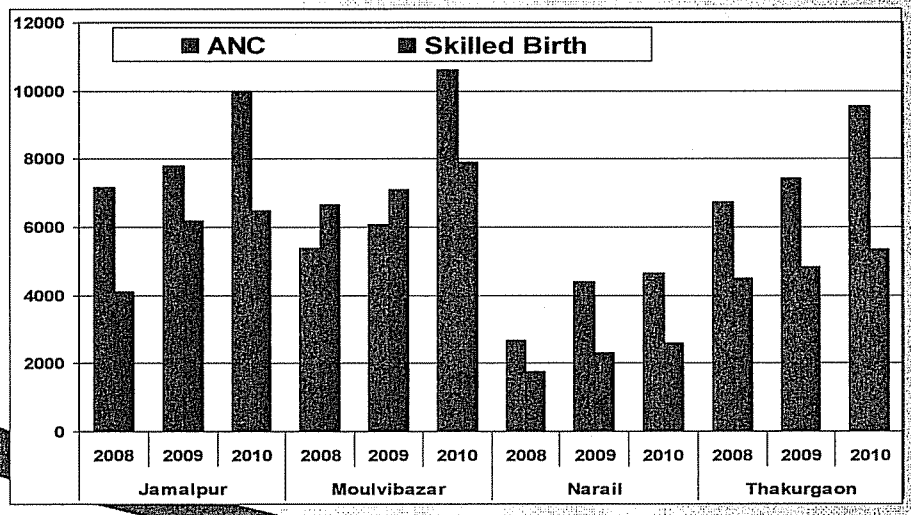
CS, Facility Delivery and Percentage Change in CS Rate (denominator: predicted deliveries) (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

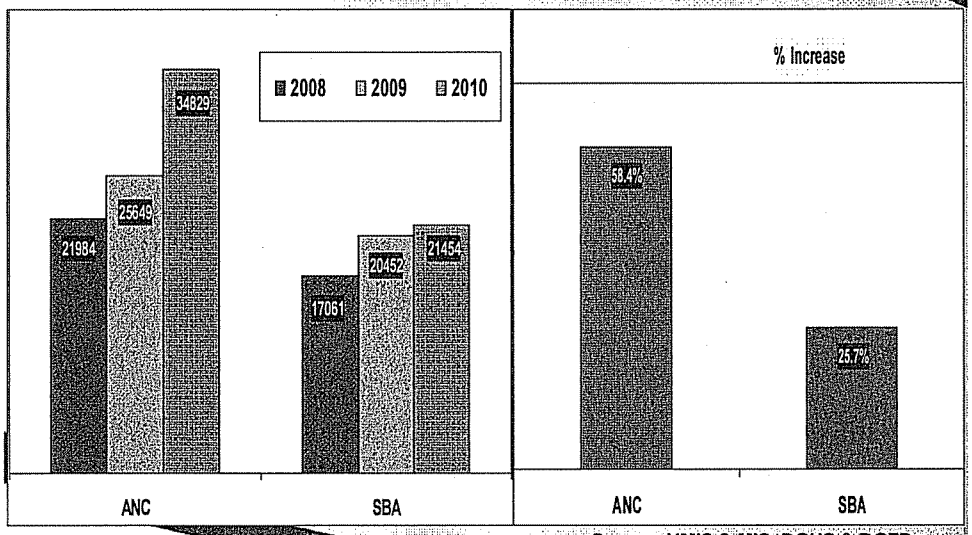
Facility Based Any ANC and Skilled Birth Attendance (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

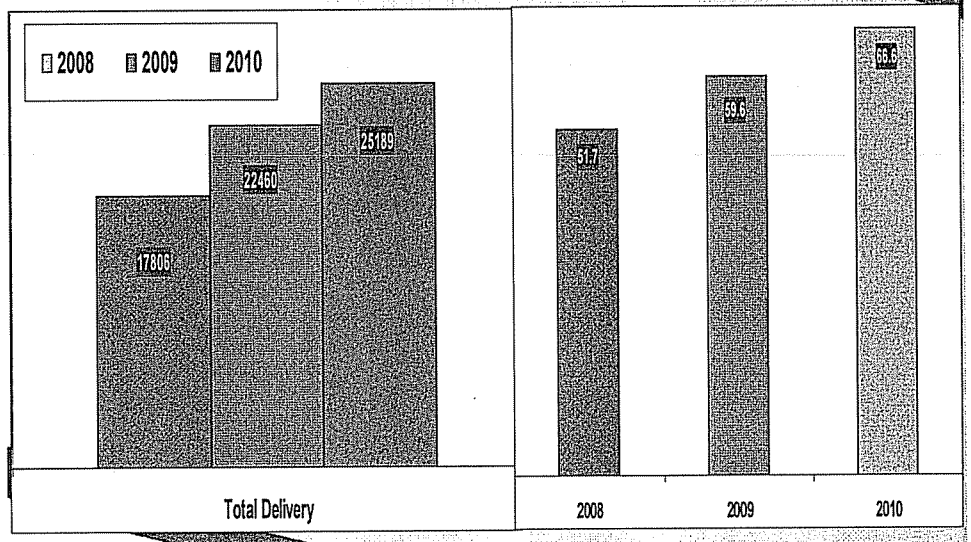
Combined Facility Based Any ANC and Skilled Birth Attendance (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

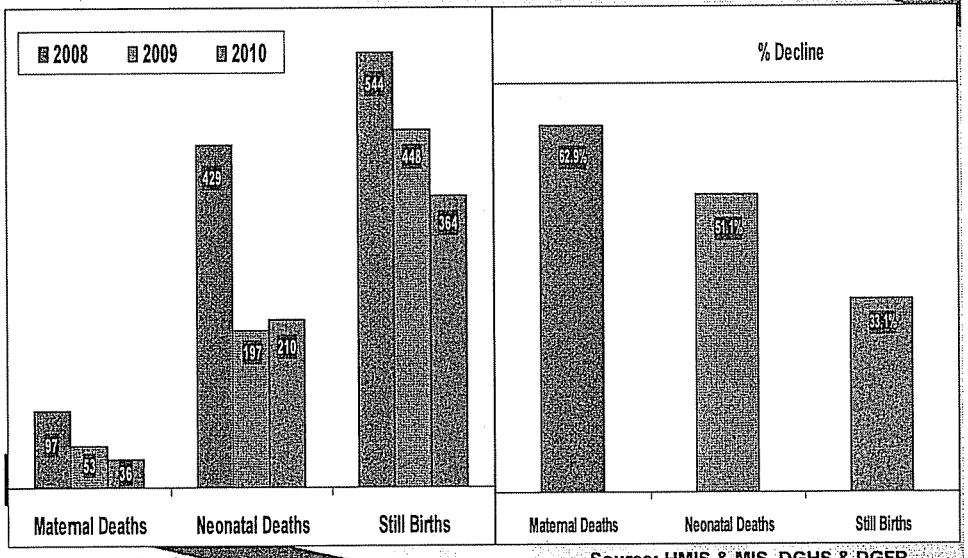
Total Deliveries and Percentage of Predicted Complications Treated (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

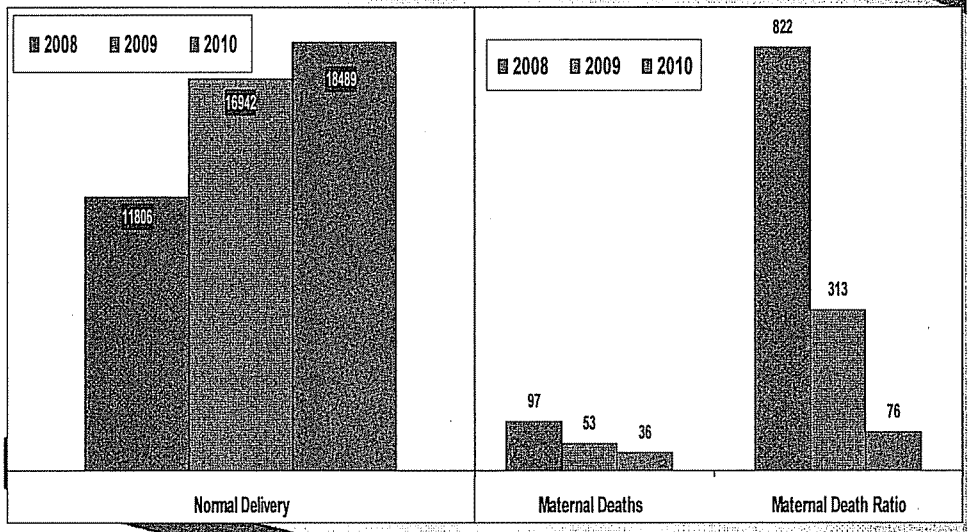
Maternal Deaths, Neonatal Deaths, Stillbirths and Percentage Change (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

Normal Deliveries, Maternal Deaths and Maternal Death Ratio in MNHI Districts (2008 to 2010)



Source: HMIS & MIS, DGHS & DGFP

Joint Maternal and Neonatal Health Initiative

ANNEXURE D: ORIGINAL MNHI LOGFRAME

LOGICAL FRAMEWORK

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
GOAL: **The reduction of maternal and neonatal mortality and morbidity in Bangladesh, with an emphasis on equity issues to achieve MDGs 4 and 5.**	1. MMR reduced from 320 to 275 2. TFR reduced from 3.0 to 2.8 3. IMR reduced from 65 to 48 4. NMR reduced from 44 to 32	1. HDS, DHS, Sample vital registration	**Assumptions:** • Government continues commitment to MNH Programme • Political stability • Donors commitment to support MNH initiative continues • Wider health and social systems improvement • Govt. remains supportive of parallel funding rather than pooled HNPSP funding. **Risks:** • Resource flows driven by district demands undermines Line Directors' control of resources • Sub optimal coordination between DGFP and DGHS at various levels. • Natural disasters
PURPOSE: **Improve community MNH practices and utilization of quality MNH care and services particularly among the poor and excluded.**	1. Forum to support and facilitate learning on effective MNH approaches formed and functional throughout project. 2. Proportion of women who have attended ANC at least three times increased by 20% from baseline by EOP with a greater proportion of increase among the poor and excluded. 3. Proportion of women delivered by Skilled Health Personnel including CSBA increased by 30% by EOP, with a greater proportion of increase among the poor and excluded. 4. Proportion of mothers who received postnatal care increased from baseline by	1. Household surveys disaggregated by poverty quintile. 2. DHS 3. Implementing agencies' and Government reports research papers, policy papers, 4. Facility clinical records.	**Assumptions:** • Knowledge of danger signs etc will lead to better decisions. • Utilization of services will increase with improved availability, quality and affordability of services • LPP process remains functional • Agencies are available and able to conduct quality BCC activities and willing to be contracted. • Social and Human Development programs run parallel **Risks:** • Long-standing human resource management constraints are not effectively addressed

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
	12% by EoP[1] with a greater proportion of increase among the poor and excluded. 5. Met need for EmOC: Proportion of complicated pregnancies predicted in the community that are appropriately managed at a functional facility increased from baseline by 15% by EOP[2].		• Social barriers to seeking care are not weakened by BCC activities, or are less weakened in poorer sections of the community.
OUTPUT 1: **District and sub-district health MNH plans developed, implemented and monitored by Health and Family Planning Management Teams with the participation of communities.**	1. 4 district plans being implemented by month 18 and 20 district plans being implemented by month 30 with participation of civil society 2. Proportion of districts that have utilized >80% of the funds allocated per plan cycle 3. Minimum 30% of annual district funds support demand side activities (predominantly) implemented by non government agencies	Project records. District planning team meeting minutes. Minutes of ComSS. District planning team monitoring and financial reports	**Assumptions:** • The District planning team will have the capacity and facilitation support of sufficient quality to produce MNH plans that pass technical appraisal committee. • Funds are used for MNH plan implementation. **Risks:** • The plans may be biased by political pressure. • Demand side activities may be out of step with supply side activities; damaging long term. • Central approval processes may cause delays.
OUTPUT 2: **Increased availability and access of a quality continuum of MNH care and services.**	1. At least one CEmOC and 4 BEmOC facilities (accredited and offering the defined services 24 hours a day, 7 days a week[3]) per 500,000 people by EOP. 2. Recorded delays in receiving treatment after arriving at CEmONC and BEmONC facility <45 minutes. 3. CS rate at project supported CEmOC facilities for appropriate indications rises from X% at baseline to 100% 4. Case fatality rate at project supported facilities for complications falls from X% at	DHS records HFPMT records. Project records User surveys Facility clinical records. Specifically established "time from arrival to treatment" registers. User surveys.	**Assumptions:** • The facilities have an equitable geographical spread. • Providers consent to keep required records, do so honestly and allow them to be scrutinized. • Clients are sufficiently aware of their rights to care and services that their "satisfaction" genuinely reflects quality of care. **Risks:** • Unnecessary CS are performed so as to reach required rates. • EmOC procedures attract under the table payments

[1] Based on an increase from national average baseline of 18% to 30%, with local baseline to be determined.
[2] Based on an increase from national average baseline of 35% to 50%, with local baseline to be determined.
[3] CEmOC and BEmOC are defined in paragraph 3.11.3 of the Joint UN Project Proposal and this indicator implies full staffing.

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
	baseline to be <1%.		and so are performed less frequently for poorer women.
OUTPUT 3: Increased demand for MNH care and services particularly by the poor and excluded.	1. Proportion of mothers who seek care from a trained provider for neonatal illness increases from baseline by 15%. 2. 100% of targeted unions with functional community support systems (ComSS) (meeting 6 times in a year and producing minutes) by EOP. 3. Increasing trend of client satisfaction with MN services over project. 4. Proportion of families having a birth preparedness plan including plans for transport in case of an emergency and the appropriate facility to attend.	Baseline and follow up surveys, exit interviews and end line survey.	**Assumptions:** • Knowledge changes women's decision making. • Knowledge among Mothers-in-law and men changes decision making. • "Intention to act" surveys may not reflect actual behaviour. **Risks:** • ComSS do not include or represent the poorest or exclude illiterate people. • Birth preparedness plans may not be followed.
OUTPUT 4: Increased equity, participation and accountability in MNH interventions.	1. All district plans implement specific strategies for reaching the poorest throughout project. 2. At least 2 innovative approaches for increasing financial access of poor and excluded tested by year 3 and depending on outcomes taken to scale. 3. Pilot maternal and neonatal "near miss" and mortality audits in selected CEmOC and BEmOC facilities. 4. 80% of ComSSs (with a gender balance) attend meetings to develop the Upazilla plan.	District MNH plans ComSS minutes and records. Focus group discussions with ComSS members.	**Assumptions:** • Planners are aware of the patterns of poverty and marginalization in their districts/upazilas. • Planners take the ComSS seriously. **Risks:** • Providers may be unwilling to record and discuss case fatality rates or be involved in "near miss" or maternal/neonatal death audits. • ComSS gets hijacked by a political elites, men, or only literate people.

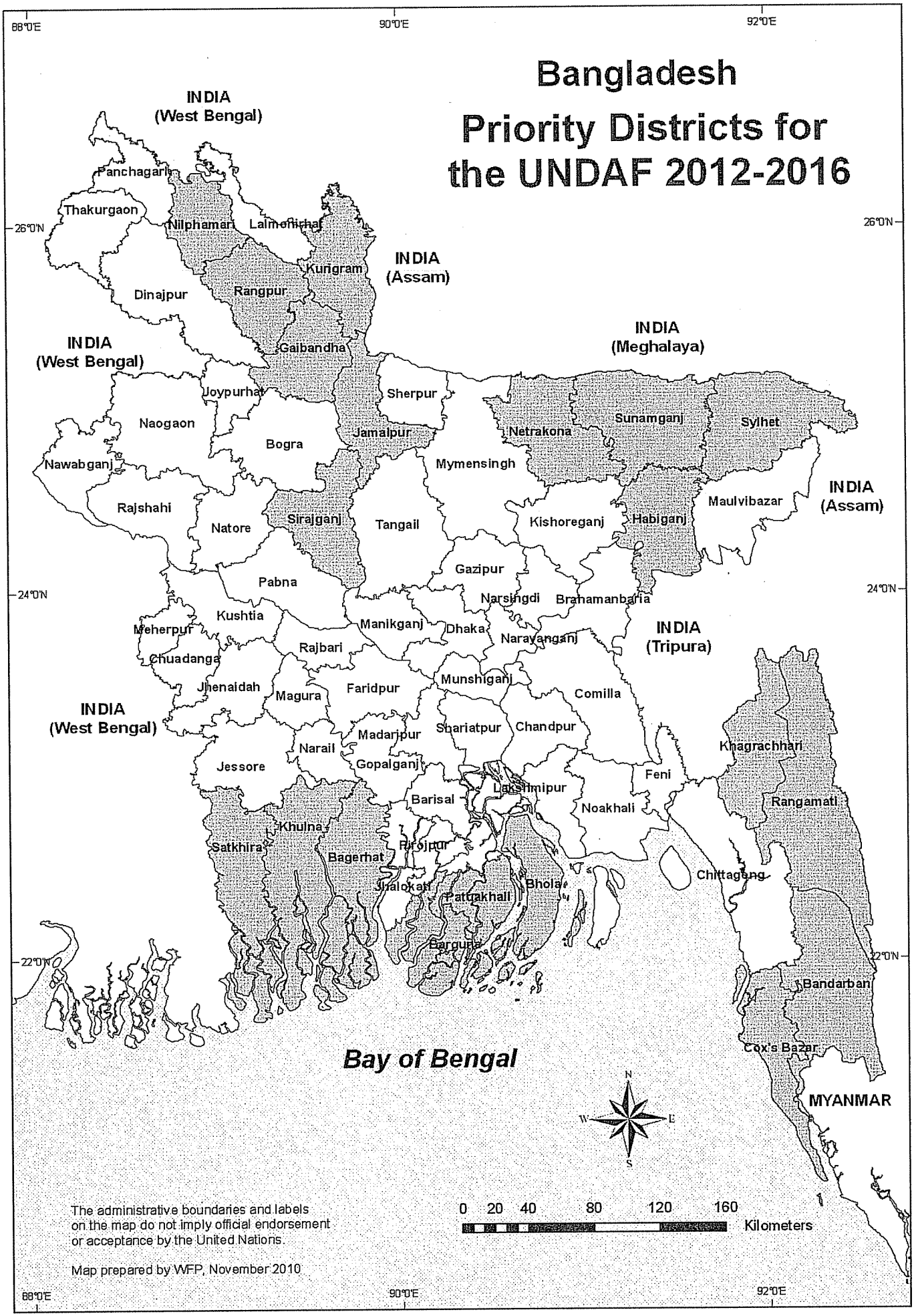
Annex-III

Benchmark/Milestone for Achievement after 18 months of Project Implementation

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
1	Project management in place and functioning efficiently and effectively.	1. Project committees established, meeting regularly and performing as per project documentation 2. All identified staff recruited, contracted, in post and functioning. 3. All UN agencies present in all joint meetings. 4. The progress report is submitted on time.	Minutes of committees. Staff contracts. Minutes of joint UN agency meetings. Progress reports.	Staff with the right skills and experience can be identified.
2	Baseline survey results available, analyzed and contributing to evidence-based district MNH planning	1. Surveys that map all supply and demand side activities by all agencies are available. 2. Surveys delivered in timely manner.	Survey data available.	Surveys are large enough and of good enough quality. Agencies are available to reliably undertake surveys.
3	Guidelines and procedures for prioritization of district MNH fund (eg what is eligible, how) agreed, codified and approved.	1. Guidelines agreed, approved and promote equity 2. LLP toolkit augmented to reflect MNH focus activities. 3. Minimum 30% of funds in each district support demand side activities, predominantly by non government agencies.	Standards identified, or if not available, adapted (or as a last resort) developed for: • Quality of care and clinical standards • Accreditation • Financial and physical asset management Guidelines produced to assist evidence-based, international best-practice-based and local context-based district MNH planning. Reports of technical appraisal of district plans.	DHS and DGFP reach agreement on guidelines and toolkits.

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
4	4 District MNH plans developed, approved, quality assured and being implemented.	District MNH plans being implemented ComSS modalities incorporated in district plan.	District plans Technical appraisal committee reports Project reports	Plans good enough to be approved. Implementation stays in line with plan. There is no political instability or interference.
5	Partnership arrangements defined and agreed.	1. Partners identified, agreed, and nature of relationship defined. 2. Activities incorporated into District plans.	Project reports Partnership agreements Contract documents	Partners of sufficient quality are available and willing to join partnerships and/or be contracted.
6	Monitoring arrangements in place and operational	1. Monitoring framework agreed and operational 2. Indicators post-18 months proposed for review	Monitoring reports	
7	Rights based approach mainstreamed across the project and plans developed to continue mainstreaming throughout to project end.	1. Participation: Civil society stakeholders participate in district MNH, including planning and monitoring. 2. Equity: District planning guidelines demonstrate pro-poor focus. Plans in place to ensure increased equity in service provision 3. Accountability: Project has mechanisms for accountability to citizens within districts, and in particular the poorest.	District MNH planning meetings minutes. Focus group discussions with present and ex-participants from civil society. An external review of all district MNH plans and their implementation to assess the extent to which they were equitable and poverty focused. Records of how accountability has been built into the project. FGDs with communities who have had or sought to had inputs to the plans.	Civil society will be interested in being participating. Participation will not be monopolized by men, elites, other interest groups. District planners want to target the poorest. District planners will agree to be more accountable.

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
8	Innovations and innovative approaches agreed and planned.	• Demand Side Financing proposal for pilot prepared. • Options to address HR problems in project districts researched and formal proposals developed for review. • Maternal and perinatal death and "near miss" audits and verbal autopsy proposal developed.	A range of models identified.	District MNH planners see demand side financing as important enough to pilot.
9	Forum for MNH operational (exchange and learning) with agreed purpose.	Forum established with agreed purpose and membership.	Minutes of meetings. Records of decisions	Membership will engage and meet regularly
10	Inventory of indicator emergency MNH drugs and monitoring of availability.	Cases of indicator MNH drug supply stockouts investigated, bottlenecks documented and reported to MoHFW decision makers for action.	Inventory Availability data	


Bangladesh
Priority Districts for the UNDAF 2012-2016
INDIA (West Bengal)
INDIA (Assam)
INDIA (Meghalaya)
INDIA (Tripura)
INDIA (West Bengal)
INDIA (West Bengal)
INDIA (Assam)
MYANMAR
Bay of Bengal
88°0'E
90°0'E
92°0'E
26°0'N
24°0'N
22°0'N
Panchagarh
Thakurgaon
Nilphamari
Lalmonirhat
Kurigram
Dinajpur
Rangpur
Gaibandha
Joypurhat
Sherpur
Naogaon
Bogra
Jamalpur
Nawabganj
Mymensingh
Netrakona
Sunamganj
Sylhet
Maulvibazar
Habiganj
Rajshahi
Natore
Sirajganj
Tangail
Kishoreganj
Pabna
Gazipur
Narsingdi
Brahamanbaria
Kushtia
Meherpur
Manikganj
Dhaka
Narayanganj
Rajbari
Chuadanga
Munshiganj
Jhenaidah
Magura
Faridpur
Comilla
Madaripur
Shariatpur
Chandpur
Narail
Khagrachhari
Jessore
Gopalganj
Feni
Lakshmipur
Barisal
Rangamati
Noakhali
Khulna
Satkhira
Pirojpur
Bagerhat
Chittagong
Jhalokati
Patuakhali
Bhola
Barguna
Bandarban
Cox's Bazar
N
W
E
S
0 20 40 80 120 160
Kilometers
The administrative boundaries and labels on the map do not imply official endorsement or acceptance by the United Nations.
Map prepared by WFP, November 2010

ANNEX F. INTERVENTION PACKAGES FOR MATERNAL AND NEWBORN HEALTH

	Universal packages (recommended in all settings)	**Situational packages** (where warranted)
Pre-pregnancy care	**Family planning** Health education to women, men families and the community Information on safe-sex, family planning, birth spacing, the availability of services including for safe abortion Counselling on and distribution of contraceptive methods including emergency contraception Screening and prevention of STIs (including HIV), cancer of the cervix and cancer of the breast.	Prevention of HIV
Safe abortion care	**Safe abortion care** Access to and provision of safe abortion care to the full extent of the law Access to and provision of treatment for complications of spontaneous and unsafe abortion WHO-recommended surgical and medical methods for uterine evacuation Contraceptive information, counselling and methods Screening, treatment and referral for other sexual and reproductive health needs.	
Care during pregnancy	**Antenatal care:** Tetanus toxoid immunization Birth and emergency planning Detection and management of complications Detection and treatment of syphilis Information and counselling on self-care, nutrition, safer sex, breastfeeding, family planning for birth spacing	Intermittent preventive therapy (IPT) for malaria Sleeping under insecticide-treated bednets Prevention of mother-to-child transmission of HIV
Care during labour, birth and 1-2 hours after birth	**Skilled care at birth:** Monitoring progress during labour Social support (companion) during birth Immediate newborn care (resuscitation if required, thermal care, hygienic cord care, early initiation of breastfeeding) **Emergency obstetric and newborn care:** Detection and clinical management of obstetric and newborn complications	Prevention of mother-to-child transmission of HIV
Postnatal/ Newborn care	**Routine postnatal care of mother and newborn:** Family planning/birth spacing information and counselling Counselling on self-care, recognition of danger signs, and key health practices Exclusive breastfeeding Thermal care Hygienic cord care Extra care of LBW infants	Prevention of mother-to-child transmission of HIV

	Prompt care-seeking for illness Immunization Management of newborn illness	

Who Will Deliver Interventions along the Continua of Care

Continua →	Interventions/ packages*	Who will deliver interventions: In the home and community	At first-level health facilities	At referral facilities
Pre-Pregnancy	***Family planning***	*CHWs provide support, information and counselling*	*Midwives, nurses and health assistants provide family planning and refer for complications*	*Nurses and doctors provide family planning provide management of methods of choices and treatment of conditions not provided at first-level facilities*
Abortion	***Safe abortion care***	*CHWs provide support, information and counselling*	*Nurses, midwives and doctors provide uterine evacuation for first-trimester and incomplete abortions, and treat common abortion-related complications*	*Skilled doctors, nurses and midwives conduct uterine evacuation for pregnancies beyond the first-trimester and manage any abortion related complications*
Pregnancy	*ANC*	*CHWs promote ANC- seeking and birth preparedness*	*Nurses and health assistants provide ANC and refer for complications*	*Nurses and doctors provide ANC for high-risk pregnancies and manage complications of pregnancy*
Birth and Immediate postnatal period	***Skilled care at birth*** ***Emergency obstetric and newborn care***	*CHWs promote skilled care at birth*	*Skilled birth attendants assist at delivery, give immediate newborn care, detect obstetric complications and*	*Skilled birth attendants assist deliveries and manage complications of labour and birth*

			refer	
Newborn period	***Routine postnatal care of mother and newborn***	*Skilled birth attendants and/ or CHWs do home visits to provide care, counsel and refer if needed*	*Nurses and health assistants give postnatal care, refer for complications*	*Nurses, doctors manage postpartum complications and severe newborn illness*

ANNEX G. DIFFERENT MNH PROJECTS

1. The Maternal, Newborn and Child Health Project (MNCH)

This is a joint BRAC and UNICEF project. It started in four districts in 2008 and expanded to ten districts in 2010. It is supported by DFID, AusAID and the Royal Dutch Embassy. The main focus of MNCH is to:

- Increase the skill and motivation of human resources to offer quality MNCH services at household and community levels.
- Enhance and strengthen referral linkage with public and private facilities.
- Involve all stakeholders and strengthen their capacities to effectively part icipate in all elements of the project.
- Increase informed demand for services.
- Facilitate the scale-up of successful approaches.

2. The Maternal, Neonatal and Child Survival Project (MNCS)

This project is implemented by the Government of Bangladesh and UNICEF with support from AusAID. It started in 2008 with a planned project life of 3.5 years. It aims to provide a package of high- impact, evidence-based interventions targeting over four million children in eight low performing districts. The three principle components of MNCS:

- Integrated Management of Childhood Illness (IMCI including Essential Newborn Care).
- Antenatal Care Plus (ANC and PNC).
- Expanded Program of Immunization Plus (EPI, Vitamin A and de-worming).

Implementation strategies include community and facility-based service delivery and also social mobilization.

3. ACCESS

ACCESS started in 2006 and is supported by USAID. This project is implemented in seven upazilas (sub-districts) of Sylhet district, covering a population of 1.5 million people. ACCESS collaborates with the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) and two national NGOs, Shimantik and Friends in Village Development, Bangladesh. Community and religious leaders, members of women's groups and local officials are mobilized involve community members at local level.

4. MAMONI

MAMONI is also supported by USAID, and is also implemented in Sylhet district. The project aims to address the high death rates among women and infants in the district through:

- Improved outreach by field workers.
- BCC for safer pregnancy and delivery.
- Improved family planning and child spacing.
- Increased awareness and use of proven, low cost methods for saving newborns.
- BCC to promote family planning.
- Strategies to provide emergency transport for pregnant women in labour.

MAMONI works in 15 upazilas coveraging some 3.5 million people.

5. Mayer Hashi

This project is also supported by USAID and the implementing partner is EngenderHealth. The main focus of Mayer Hashi is to build the capacity of government and NGOs to provide quality Family Planning services. The project aims to:

- Improve women's and children's health by increasing awareness of and access to long-acting and permanent methods (LAPM) of family planning.
- Raising awareness among health care workers of obstetric and neonatal emergencies allowing them to identify and treat them at an early stage.
- Extend the coverage of its Misoprostol PPH prevention intervention.

6. Safe Motherhood Promotion Project (SMPP)

SMPP is funded by JICA and implemented in one district (Narshingdi) but is planned to expand to several coastal districts. SMPP works in collaboration with MoHF. The project started in July 2006 covering 2.2 million people. The project focuses on:

- Strengthening health systems and management.
- Ensuring safe delivery services.
- Promoting Community Participation.

ANNEX H: DESCRIPTION OF UNFPA BANGLADESH PROGRAMME

1. UNFPA- GoB collaboration through 7th Country Programme

The current country programme (CP) covers the period 2006-2010 with the extension till 2011. The aid modalities and programme delivery emphasises capacity development, service delivery with particular focus on the poor and vulnerable and added gender dimension in the programme with emphasis on the Gender-Based Violence (GBV). In keeping with the commitments made by the government through MDGs (1, 3, 5, and 6 with a greater thrust on 3 and 5), ICPD '94, and Beijing Platform for Action, and in conformity with UNDAF framework, the 7th CP directly addresses the national priorities in health and population sector. The specific outcomes of the 7th CP are:

- Population and reproductive health related strategies effectively translated into programmes, especially for the poor and vulnerable;
- Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS;
- A policy environment that promotes reproductive health and rights is created; and
- Women and girls are supported and empowered to make decisions about their reproductive health and rights.

To achieve these outcomes, the programme is implemented through three mutually re-enforcing components: ***1) Reproductive Health***; ***2) Gender***; and ***3) Population and Development***. While some interventions are national in scope (e.g., advocacy, contraceptive security and components that are part of HNPSP (SWAp), many of the CP activities are concentrated on two underserved and low performing districts (i.e., Cox's Bazaar and Sylhet). The district level programme interventions are being coordinated and monitored through two field (district) offices.

1) REPRODUCTIVE HEALTH (RH)

The RH component supports and is fully integrated within the health sector SWAp (HNPSP 2003-11) through parallel funding, with a small proportion of funds (US$ 1 million) channeled through World Bank administered pool funding. Programme outputs to be achieved through the RH component include: i) increased access to improved SRH information and services; ii) increased demand especially among poor and vulnerable for SRH services; iii) SRH needs and education of young people addressed; iv) improved awareness and prevention about RTI/STI/HIV/AIDS among young people and high-risk groups.

Main implementing partners:

Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS) of Ministry of Health & Family Welfare; and Urban Primary Health Clinics of Ministry of Local Government, Rural Development & Cooperatives; Ministry of Youth and Sports; Ministry of Education; and NGOs such as Research Training & Management International (RTMI) for interventions in Rohinga Refugee camps, Bandhu Social Welfare Society (BSWS) and HIV/AIDS Allience in Bangladesh (HASAB) for HIV interventions.

Notable achievements to date:

- *FP/RH* - With UNFPA assistance (training, provision of essential drugs, medical, surgical and other equipments, etc.), 70 Maternal Child Welfare Centres (MCWCs), 20 Upazila Health Complexes (UHCs), and 30 urban clinics deliver FP and EmOC services nationwide; a national Communication Strategy for FP/RH developed.
- *Maternal mortality reduction* - Poor vulnerable pregnant women of 3 upazilas of Cox's Bazaar district are receiving financial support under National Pilot Programme of "DSF/Maternal Voucher Scheme" partially supported by UNFPA to get access to EmOC services; About 5,500 community workers trained as Community based Skilled Birth Attendants (CSBAs) to provide services in 60 districts; A strategic direction document enhancing contribution of nurse/midwives for midwifery

services developed in 2009 with emphasis on Policy-Planning, Training-Education, Deployment-Utilization, including certification and regulation by the Government.

- *Fistula* - A National Fistula Centre established along with 9 fistula corners at 9 Medical Colleges Hospitals. Thirty five (35) repaired fistula patients trained as Community Fistula Advocates (CFA) and rehabilitated in their own community for advocating "Campaign to end Obstetric Fistula" in Bangladesh.
- *Peer approach for Adolescent Reproductive health (ARH)* - ARH Strategy developed. 263 Peer educators who work through 50 youth clubs, 80 core trainers and 200 peer educators who work through 40 schools have been trained. About 4000 adolescent and youth from schools and 4500 boy scouts and girls' guides have been trained on ARH/life skills. National Youth Forum established and actively involved in advocacy (2010 theme is "Preventing Early Marriage").
- *Health sector response to VAW* - Establishment of One Stop Crisis Centre (OCC) in Cox's Bazaar District Hospital supported through training of service providers.
- *HIV* – National Partnership Forum formed on the issues of HIV and Sex work. Adolescents are working as advocate through different print and electronic media and at private universities for adolescent supportive national policy and health care system.

2) GENDER

The gender component is focusing primarily on gender equity and equality and women's empowerment, GBV, raising awareness on gender issues and development of local coalitions for promoting women's rights especially through involving men, boys and leaders of influence such as religious leaders and parliamentarians. The expected output of this component is: Rights of women and girls promoted and gender equity enhanced.

Main implementing partners:

Ministry of Women and Children Affairs, Ministry of Information, Ministry of Labour & Employment, Ministry of Religious Affairs, Ministry of Home Affairs, Bangladesh Garment Manufactures & Exports Association (BGMEA).

Notable achievements to date:

- *Support to Women Support Centre* - With UNFPA assistance, 2 Women Support Centres (WSCs) in Sylhet and Cox's Bazaar provides services to the survivors of VAW in the area of legal aid, treatment, psychosocial counseling, shelter, food assistance, adult and child literacy and vocational training for income generating activities. To date 584 women (and 592 children) and 52 women (and 57 children) took shelter in Sylhet and Cox Bazaar WSCs respectively.
- *Engaging Men and Boys to end GBV* - A national network established with the organizations working on engaging men and boys to end GBV. A South Asia Regional consultation on working with boys and men for gender equality and GBV prevention took place in Dhaka in 2009.
- *Community sensitization* - Religious leaders oriented on the issues of RH and rights, gender, and HIV/AIDS, now are instrumental in sensitizing communities through interactive meetings and delivering lectures in the mosques, etc., for changing societal attitude positively towards gender, women and girls' rights and prevention of violence. Messages have also been disseminated to general public through mass media, film show, folk songs, etc., under the project with Information Ministry.
- *Sensitization of marginalized women* - About 4,000 women working in garment and tea plantation sectors oriented and increased knowledge on RH and rights, laws on dowry, early marriage, and gender equality.

3) POPULATION & DEVELOPMENT (P&D)

The P&D component is emphasizing the utilization of gender and poverty disaggregated data for development planning and poverty reduction. It includes, amongst others, capacity development for population research, data collection and training, and advocacy on population, gender, and RH and rights at national and sub-national levels. Programme outputs to be achieved through the component include: i) Population and gender concerns integrated into national and sectoral plans; ii) Improved analysis and utilization of data disaggregated by age, sex, economic status and location.

Main implementing partners:
Population planning wing of Planning Commission, Bangladesh Bureau of Statistics (BBS), Population Science Department of Dhaka University, Bangladesh Parliament Secretariat, National Institute of Population Research and Training (NIPORT) of Ministry of Health & Family Welfare.

Notable achievements to date:

- *Research and Advocacy* – A number of researches conducted by NIPORT with some of the findings utilized for policy advocacy and programme formulation. Parliamentarians oriented on the population issues, now play major roles in advocacy initiatives. Formation of 2 parliamentary sub-committees on Youth and HIV/AIDS is the milestone achievement.
- *Strengthening Department of Population Sciences, Dhaka University* - In order to create pool of Population Scientists in-house, UNFPA facilitated the establishment (in 1998) and strengthening of Department of Population Sciences in the University of Dhaka. To date, over 200 masters and about 100 diplomas awarded in Population Sciences.
- *Digitized EA Mauza Maps* - With UNFPA assistance, BBS is preparing digitized enumeration area (EA) mouza maps towards producing GIS base maps, which will be used for census 2011.

2. UN-GoB joint maternal and neonatal health initiative (MNHI) (2007-2012)

UNFPA leads the joint MNHI where the GoB and 3 UN agencies (UNFPA, UNICEF, and WHO) work collectively to accelerate the progress towards maternal and neonatal mortality and morbidity reduction (MDG 4 & 5) with an emphasis on equity issues. With a view to improving community MNH practices and utilisation of quality MNH care and services particularly among the poor and excluded, the project adopts an innovative rights-based approach that combines supply and demand side interventions based at district level. The project was signed on 7 June 2007 for US$31.2 million, with DFID and EC funding. The first phase of implementation covers 4 districts (Thakurgaon, Narail, Moulvibazarr and Jamalpur) with scope to scale up in the additional districts in phase 2. The project beneficiaries include 47.5 million mothers and newborns.

3. UN-GoB joint programme on Violence Against Women (VAW) (2010-2012)

Three-year UN-GoB joint programme on VAW, funded by Spanish MDG Fund (US$8 million), kick started its implementation. UNFPA is the lead agency of the programme that involves 9 UN agencies (UNFPA, UNIFEM, UNICEF, WHO, ILO, UNESCO, IOM, UNDP and UNAIDS) and 11 GoB implementing partners. The programme will address the issues related to policies and implementation of the adopted laws and conventions, the attitudes and behaviour of men and women, boys and girls themselves, and provide survivors of VAW with immediate relief and rehabilitation.

4. Population and Housing Census (2011 - 2013)

The Government is preparing for the 5th Population and Housing Census in 2011. UNFPA supports the Government, particularly the Bangladesh Bureau of Statistics (BBS) in conducting the census in all three phases (Pre-census, actual census/enumeration, and post census activities). Overall UNFPA assistance is focusing on the development of capacity of BBS for conducting and efficient management of the census as well as procurement of equipment for data capturing and analysis, including printing. UNFPA is also providing technical support in several important areas, such as engendering census, inclusion of maternal mortality and disability, migration and preparation of reports. UNFPA secured funding about €10.4 million from the Delegation of the European Union as well as contributing from its own resources. The project will continue until the end of 2013.

ANNEX I. BUDGET SUMMARY (CIDA CONTRIBUTION) (CAD) *

	Year 1	Year 2	Year 3	Year 4	Year 5	Total (CAD)
Sub Total Human Resources	739,132	1,133,500	1,398,158	647,421	724,446	4,642,656
Sub Total Travel	27,421	-	29,578	32,659	18,281	107,938
Sub Total Equipment & Supplies	160,828	3,697	3,697	3,697	3,697	175,617
Sub Total Local Office	165,552	132,278	132,278	396,833	396,833	1,223,773
Output 1 intervention	403,611	484,898	494,765	494,935	325,549	2,203,758
Output 2 intervention	1,181,862	1,392,351	1,505,824	993,024	385,158	5,458,220
Output 3 & 4 interventions	852,410	919,165	919,165	898,625	25,675	3,615,040
M&E	143,780	82,160	51,350	51,350	205,400	534,040
Documentation, dissemination, and visibility	42,621	69,836	72,147	77,539	95,511	357,653
Sub Total Programme Cost	2,624,284	2,948,410	3,043,251	2,515,473	1,037,293	12,168,711
A. Direct Cost Total	3,717,217	4,217,885	4,606,961	3,596,082	2,180,549	18,318,695
B. Overhead 7% (0.07*A)	260,205	295,252	322,487	251,726	152,638	1,282,309
C. Total (A+B)	3,977,422	4,513,137	4,929,448	3,847,808	2,333,188	19,601,003
D. Administrative Agent's Fee 1% (0.01*E)	40,176	45,587	49,792	38,867	23,568	197,990
E. GRAND TOTAL (C+D)	**4,017,598**	**4,558,724**	**4,979,240**	**3,886,675**	**2,356,755**	**19,798,993**

N.B. Exchange rate: 1 CAD = 1.027 USD

*** Out of $19,798,993 budgeted for the programme, CIDA will contribute $19,750,000**