IMPROVING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN DHAKA PROJECT

Background

Urban Bangladesh continues to face major public health challenges, including unmet need of contraception, high incidence of unsafe abortion, child marriage, early pregnancy, and SGBV, particularly among slum dwellers, the underserved population, female garment workers, and adolescents. Despite MR being an essential service in Bangladesh, women and girls face stigma and barriers to accessing MR and PAC. Ministry of Health is not assigned to provide primary health care for the urban population. General Practitioners offer affordable services, but their potential is constrained by inadequate training, capacity, and essential commodities.

Goal **Improved sexual and reproductive health and rights of underserved and vulnerable women and adolescents in Dhaka**

Outcomes

- Improved availability and accessibility to quality SRH services for poor and ultra-poor women and adolescents living in urban areas even in public health emergencies
- Increased social support, knowledge, self-efficacy related to SRHR, including SGBV resources for women and adolescents of low socio-economic groups in urban areas
- Improved public health emergency preparedness and response to ensure access to and uninterrupted delivery of essential SRH services & supplies during public health emergencies

Geographical areas	Target population
• Dhaka North City Corporation • Dhaka South City Corporation • Gazipur and Narayanganj specifically the Garments area	• Urban underserved population • Urban low socioeconomic group • Women particularly adolescents and youth • Female garments factory workers

Project Period: August 2021 – June 2026

Brief 1
Capacity and Competency Building of Service Providers

Background

Access to quality SRHR services in urban Bangladesh is often limited by gaps in providers' knowledge, skills, and confidence in delivering Family Planning (FP), Menstrual Regulation (MR), Post-Abortion Care (PAC), and Sexual and Gender-Based Violence services. Many providers have limited opportunities for competency-based training and continuous professional development, affecting the quality and responsiveness of care. To address these challenges, the project strengthened provider capacity through clinical training and implemented Values Clarification and Attitude Transformation (VCAT) workshops to reduce stigma, challenge misconceptions, and promote respectful, rights-based, client-centered service delivery.

Objective

- To strengthen the capacity of healthcare providers across the urban health system to deliver quality, evidence-based, respectful, and client-centered SRHR services.
- To reduce stigma and provider bias related to MR, PAC, FP, adolescent SRHR, and SGBV through Values Clarification and Attitude Transformation (VCAT), while promoting self-reflection on professional responsibilities, gender norms, and reproductive rights.

Approach and Key Interventions

Competency-Based Clinical Training

ISRHRD project implemented comprehensive clinical training packages on:

- Comprehensive MR, PAC and FP
- MRM, mPAC and FP including post MR, post abortion FP
- Family Planning (short-acting and LARC methods)
- Infection Prevention and Control (IPC)
- Sexual and Gender-Based Violence (SGBV) identification, referral and reporting
- Values Clarification for Action and Transformation (VCAT)

The trainings followed DGFP-approved standardized curricula that combined with classroom-based theoretical learning, simulation and dummy-based practice, supervised clinical practicum with clients and competency assessment through pre and post tests

Training on MRM, mPAC and FP

Refresher and Skill Update Sessions

To address skill attrition and reinforce learning, refresher trainings and skill update sessions were conducted six months to one year after initial training. These sessions focused on:

- Reinforcing clinical competencies
- Updating providers on evolving national protocols
- Addressing service delivery gaps identified through monitoring
- Strengthening confidence in provision of MR, PAC, FP (including interval and post MR, post abortion FP) and SGBV-related services

Continuous Mentorship and Follow-up

Clinical trainers and project health system teams conducted regular follow-up visits, mentoring, coaching, and supportive supervision to facilitate translation of knowledge into routine practice.

Results

In total 710 providers trained on competency-based MR, PAC, FP and SGBV services

Provider Category	Number Trained
Doctors	399
Mid-Level Providers (MLPs)	291
General Practitioners (GPs)	130
Total	**710**

Brief 2
Facility Readiness for Quality and Respectful SRHR Service Provision

Background

Provider competency alone cannot ensure quality SRHR services without adequate facility readiness. Many urban health facilities face challenges related to shortages of equipment, commodities, infection prevention supplies, privacy arrangements, and standardized recording and reporting systems. These gaps often compromise service quality, client experience, and continuity of care. Strengthening facility readiness is therefore essential to creating an enabling environment for quality and respectful SRHR service provision.

Objective

To strengthen the readiness of public/ private workplace, and referral health facilities to provide safe, quality, respectful, and uninterrupted SRHR services, including FP, MR, PAC, and SGBV-related care.

Approach and Key Interventions

Facility Assessment and Readiness Strengthening

Systematic facility readiness assessments were conducted to identify gaps in:

- Equipment, instruments, essential medicines and commodities,
- Infection prevention supplies
- Privacy and counselling arrangements
- Service recording and reporting systems
- Providers skill and competency
- IEC materials

Equipment, Commodity and Logistics Support

Facilities received support to ensure uninterrupted availability of MR and PAC equipment, Family planning commodities, IPC supplies, Service registers and reporting tools and essential medicines. Gradually, facilities were linked with DGFP logistics systems to promote sustainability.

Establishment of Training Centers and Skill labs

The project strengthened training capacity by establishing and enhancing training centers at tertiary hospitals for MR, PAC, and FP services. It also established skill labs equipped with simulation-based learning materials at urban health facilities, creating sustainable learning platforms for cascading clinical skills, on-the-job training, skill transfer to newly recruited staff, and continuous skill updates for existing providers to ensure quality SRHR service delivery.

Digital Reporting and Health System Integration

The project introduced app-based recording and reporting systems for GPs, implemented combined Family Planning register at countrywide UPHCSDP clinics and project supported garment factories, updated online reporting system of UPHCSDP MIS with revised FP, MR, PAC, and VAW/GBV indicators and strengthened coordination around HMIS integration, LMIS strengthening, Referral linkages and Commodity management systems.

Results

165 facilities strengthened for SRHR service delivery-

- SRH equipment, commodities and logistics supplied across 165 facilities.
- Five tertiary-level training centers established /strengthened.
- 14 skill labs at urban clinics and referral hospitals for demonstration and practice of MVA and LARC service established.
- Implemented combined Family Planning register at countrywide UPHCSDP clinics and project supported garment factories.

Brief 3
Strengthening Urban SRHR Services through the General Practitioner (GP) Model

Background

Rapid urbanization in Bangladesh has created significant inequities in access to SRHR services, particularly among women, adolescents, slum dwellers, and low-income populations. Although GPs are often the first point of contact for healthcare in urban communities due to their accessibility, affordability, and community trust, they have historically been underutilized in SRHR service delivery because of limited technical training, inadequate commodities, weak referral linkages, and lack of integration with the formal health system. Recognizing this opportunity, the Improving SRHR in Dhaka project introduced an innovative GP model to strengthen the role of private GPs in providing quality FP which includes interval and post MR, post abortion FP, MRM, mPAC, and SGBV services. A systematic mapping process identified and assessed GPs practicing in underserved urban communities.

Objective

To improve the availability, accessibility, and quality of SRHR services for underserved urban populations by integrating trained GPs into the urban health system and strengthening linkages between communities, private providers, public facilities, and referral services.

Capacity Building and Facility Readiness

A six-day DGFP-recognized competency-based training package was provided on MRM, mPAC, FP (including interval and post MR, post abortion FP), counselling, IPC, and SGBV identification and referral. Refresher training, mentorship, supportive supervision, and clinical updates were conducted regularly to ensure skill retention and quality service delivery. GP chambers were upgraded with essential equipment, infection prevention materials, counselling aids, FP commodities, MRM supplies, and branding materials to ensure readiness for quality SRHR service provision.

Community Linkage through Youth Volunteers

Each GP was linked with ten trained youth volunteers who conducted awareness activities, promoted SRHR services, and referred clients from the community to GP chambers. This created a strong bridge between underserved communities and formal healthcare providers.

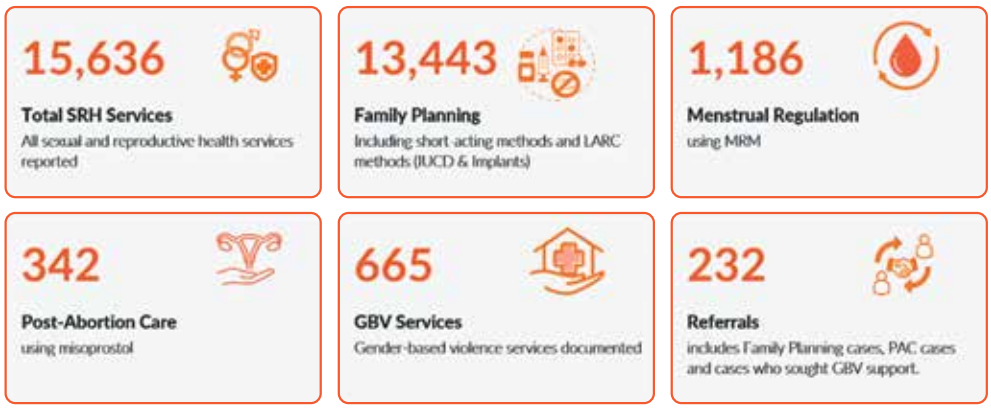
Referral and Reporting Systems

Structured referral pathways were established between GP chambers, UPHCSDP clinics, tertiary hospitals, and SGBV support services. A digital reporting platform was introduced to strengthen accountability, service tracking, and data-driven decision-making.

Results

The GP model successfully transformed private GP chambers into community-based SRHR service delivery points:

- **130 General Practitioners** trained and engaged in SRHR service provision.
- **100 GP chambers** strengthened and branded as quality SRHR service centers.



Brief 4
Social Behavior Change Communication (SBCC) and Community Engagement: Empowering Communities, Transforming Norms, Improving SRHR Outcomes in Urban Dhaka

Background

Women, adolescent girls and boys living in low-income urban communities in Dhaka often face multiple barriers to accessing sexual and reproductive health and rights (SRHR) information and services. Limited knowledge, social stigma, gender norms, misinformation, and inadequate social support frequently hinder informed decision-making and timely care-seeking.

To address these challenges, the Improving SRHR in Dhaka Project integrated Social and Behavior Change Communication (SBCC) and Community Engagement as core components of its intervention strategy. Aligned with the project's objective of increasing knowledge, social support, and self-efficacy among women and girls, these interventions aimed to create an enabling environment where individuals could access accurate information, discuss SRHR issues openly, and confidently seek quality services.

The Underlying Theory of Change

When communities receive accurate information, engage in open dialogue, observe positive role models, and have access to trusted service providers and referral systems, they are more likely to develop confidence, reduce stigma, support informed decision-making, and seek timely SRHR services.

Approach and Strategic Interventions

The project adopted a comprehensive and integrated strategic approach that combined community mobilization, youth leadership, interpersonal communication, advocacy, digital engagement, and service visibility. To achieve this, the project developed SBCC, youth engagement and social media strategies, and invested simultaneously in people, systems, communication platforms, and community structures.

Youth Engagement: Transforming Young People into Change Agents

The project engaged and empowered 1,510 youth volunteers as peer educators, community mobilizers, advocates, and referral supporters. Through training, mentoring, and practical engagement, they strengthened their knowledge and skills in SRHR, VCAT, communication, leadership, advocacy, digital engagement, community mobilization, and innovative approaches such as interactive theatre and Photovoice. Youth volunteers played a vital role in connecting women and adolescents with GPs, urban clinics, telemedicine services, and referral facilities. Through school campaigns, community awareness sessions, rallies, door-to-door outreach, and referral support, they promoted informed decision-making and access to services. The initiative demonstrated the potential of youth as trusted community leaders and effective agents of social and behavioral change.

Youth volunteers in orientation.

GP-Volunteers networking meeting.

Youth volunteer facilitating community awareness session.

Using Creativity to Break Silence and Lasting Awareness

Addressing sensitive SRHR issues requires approaches that encourage dialogue rather than simply disseminating information. The project therefore invested in innovative community engagement methodologies including Interactive Edutainment Drama, Photovoice and Storytelling, interactive games that helped community people bring into open conversations on SRHR issues.

Photovoice and Storytelling

The project empowered youth to document community realities through Photovoice. Volunteers captured stories related to SRHR challenges, service barriers, menstrual hygiene, gender-based violence, and community resilience.

42 Photovoice stories were showcased through local and national exhibitions, creating opportunities for dialogue among community members, local leaders, policymakers, and development stakeholders.

Photo and story selection session. ©Ipas Bangladesh

National level Photovoice exhibition. ©Ipas Bangladesh

Photovoice elevated community voices, transformed lived experiences into advocacy evidence, and enhanced open public conversations on reproductive rights and social justice.

Interactive Edutainment Drama

Youth volunteers were trained to conduct interactive theatre performances on menstrual regulation (MR), family planning, early marriage, unintended pregnancy, and gender-based violence.

- **15** community theatre performances conducted
- **7,500+** women, men, and adolescents directly engaged
- **30,000+** community members reached through wider audience participation and discussions
- **45%** of male engagement in each show

Interactive edutainment drama show. ©Ipas Bangladesh

The interactive nature of these performances enabled audiences to question, reflect, and discuss issues that are often considered as taboos, contributing to stigma reduction and increased awareness.

Strengthening Community-Level Communication Systems

To mobilize communities toward accessing SRHR services, **232 Outreach Workers from urban clinics were trained** on SBCC, gender-based violence, interpersonal communication, community mobilization, counselling approaches, and the use of communication materials.

Outreach Workers conducted household counselling, courtyard meetings, community discussions, and awareness events across project areas. They provided information on menstrual regulation, post-abortion care, contraception, and gender-based violence.

Training on SBC for outreach workers.

Courtyard session by outreach worker.

A range of SBCC materials—including job aids, facilitation tools, and take-home materials for outreach workers and community were developed and used to reinforce key messages and strengthen interpersonal communication efforts.

Increasing Visibility and Trust in SRHR Services

Before Branding

After Branding

Community awareness is most effective when people can easily identify and access trusted service providers. To improve service visibility and community trust, the project branded 120 GP chambers with standardized signage and service information, strengthening recognition of available SRHR services. The intervention also promoted telemedicine services, including the OGSB Call Center, helping expand access to reliable SRHR information and counselling beyond traditional facility settings.

A wide range of SBCC materials—including posters, leaflets, stickers, job aids, facilitation tools, and take-home materials were developed and used to reinforce key messages and support interpersonal communication efforts.

Together, these efforts strengthened referral pathways and improved linkages between community awareness and service utilization.

Expanding Reach Through Digital Engagement and Advocacy

Recognizing the growing influence of digital platforms, the project supported youth-led digital engagement initiatives to increase access to accurate SRHR information and foster meaningful public dialogue. Youth volunteers were trained and engaged in SRHR content development for the Project's social media platforms- Facebook, Instagram, You Tube.

- **1.75+ million people reached** through the project's digital platforms
- **154,940 engagements** generated through likes, comments, shares, and interactions

The project's digital engagement strategy complemented community-based activities by extending the reach of evidence-based SRHR messages to wider audiences, particularly young people.

Youth Leadership and Policy Advocacy

The project enhanced youth leadership and strengthened youth participation in policy dialogue. Through the National Urban Youth Conference, youth leaders presented a 16-point advocacy declaration highlighting key health and SRHR priorities. This initiative amplified youth voices, promoted civic engagement, and created opportunities for young people to contribute to discussions and decisions affecting their communities.

Bangladesh Urban Youth Conference 2025 (BUYC 2025)

Youth leaders present 16-point demand on SRHR during BUYC 2026

Key Lessons

- Empowered youth can effectively mobilize communities and create supportive environments for women and girls to access SRHR information and services.
- Interactive approaches such as photovoice, edutainment drama, and games are effective in engaging men and boys on SRHR issues.
- Both digital and community-based interventions are essential for community awareness, addressing stigma, myths, and misinformation about SRHR

Evidence of Change and Community Impact

- Youth as Trusted Information Source-

  20% in 2025 from less than 5% in 2022.
- **45 %** men engagement in interactive edutainment drama is signaficant in terms of male engagement on SRHR Issues.
- **100,539** women-adolescents-men reached through youth-led community campains, school sessions, health camps and interactive edutainment drama.
- **1.048** million people reached through outreach workers' courtyard meetings, door to door visits.
- **1.75+** million reached through project digital platform

Conclusion

The Improving SRHR in Dhaka Project demonstrates that integrating SBCC, community engagement, youth leadership, and service linkages can effectively improve awareness, social support, and access to SRHR services. The experience offers a practical and scalable approach for advancing equitable SRHR outcomes in urban Bangladesh.

Stop Violence

Brief 5
Sexual and Gender-Based Violence (SGBV)

Introduction

The Improving SRHR in Dhaka Project recognizes that addressing SGBV is essential to achieving better health outcomes, advancing gender equality, and ensuring that all individuals can exercise their sexual and reproductive rights safely and with dignity. The project considers the consequences and addresses the challenges by integrating SGBV within SRHR programming and strengthening coordination among health facilities, community organizations, legal service providers, and protection actors. Through an integrated and survivor-centered approach, the project strengthens prevention, response, and referral systems to ensure that survivors receive timely, confidential, and comprehensive support.

Approach

The project adopts a comprehensive, rights-based, and survivor-centered approach that prioritizes safety, dignity, confidentiality, and informed consent. It seeks to ensure that survivors have access to quality services while simultaneously addressing the underlying factors that contribute to violence and discrimination. The comprehensive GBV approach ensures early identification, strengthens prevention systems, and delivers timely, survivor-centered response services.

A continuum approach to SGBV programming

Identification → **Survivor-centered response** → **Referrals**

Guiding Principles

All SGBV interventions under the project were guided by internationally recognized principles:

- **Survivor-Centered Approach:** Respecting survivors' choices, needs, and autonomy
- **Confidentiality:** Protecting personal information and ensuring privacy.
- **Safety and Do No Harm:** Prioritizing the safety of survivors and minimizing risks.
- **Non-Discrimination:** Ensuring equitable access to services for all individuals.
- **Rights-Based Approach:** Promoting dignity, equality, and human rights.

Expected Outcomes (Theory of Change)

Areas of Intervention

1. Strengthening Survivor-Centered Health Services

The project supported health facilities, service providers and community health workers to strengthen their capacity to identify, respond to, and refer SGBV cases appropriately with training on counseling on GBV and Reproductive Coercion with survivor-centered care, ethical principles, trauma-informed approaches, and referral procedures to improve the quality and sensitivity of services.

GBV and RC Counseling (ToT 79 and Training 432): 511 Service Providers
Training on Referral Pathway for GBV survivors: 151 Service Providers

2. Referral Pathway for GBV Survivors in Urban Setting

Recognizing the need of a formal referral protocol to support sexual and gender-based violence survivors, the project developed an outline of **Referral Pathways for GBV Survivors** living in urban settings for health, psychosocial, legal, and shelter services which has been followed by an **Implementation Study** to evaluate its functionality and effectiveness of the developed outline.

"From Assessment to Action: Strengthening the GBV Referral Pathway (2023–2026)"		
ASSESS **2023–2024**	**DESIGN & DEVELOP** **2024–2025**	**STUDY: EVALUATE** **2026**
• Reviewed existing referral mechanisms • Identified strengths, gaps, challenges • Generated evidence-based recommendations	• Developed the referral pathway framework • Consulted and engaged key stakeholders • Shared the pathway for validation and implementation	• Assessed functionality and effectiveness • Examined implementation experiences • Informed future strengthening and scale-up

3. Community Awareness and Prevention

For SGBV prevention and promoting Zero Tolerance against Violence, community based mass awareness campaigns, dialogues and sessions on gender equality and SRHR, engaging 1000 youth volunteers and social media campaigns were organized that contributed to addressing harmful social norms, increase awareness of rights, and reducing stigma, encouraging help-seeking behavior, and promoting a culture of respect and non-violence.

Result

A total of 11,450 GBV cases were counseled and treated during the reporting period (January 2022–March 2026) through project supported health clinics of Urban Primary Health Care Services Project (UPHCSDP), secondary and tertiary level referral hospitals, general practitioners and garments health clinics throughout the project period.

Conclusion

The Improving SRHR in Dhaka Project laid a strong foundation for a more coordinated, accessible, and survivor-centered response to Sexual and Gender-Based Violence (SGBV). The project's achievements and strengthened systems provide a valuable basis for sustaining progress, informing future efforts to promote gender equality, integrate gender-responsive approaches into the health system, and expand equitable access to SRHR services in urban settings.

Brief 6
From Fragmentation to Integration: Strengthening SRHR Data Systems in Urban Bangladesh

Background

The *Improving Sexual and Reproductive Health and Rights (SRHR) in Dhaka project* delivers comprehensive Family Planning (FP), Menstrual Regulation (MR), Post-Abortion Care (PAC), and Gender-Based Violence (GBV) services to women and adolescent girls living in low-income urban areas of Dhaka. The project works through a diverse network of service delivery points, including referral hospitals, urban primary care clinics, garment factory clinics, and private general practitioners (GPs).

At the outset, the project identified significant inconsistencies across these facilities in both service provision and health information management system. Record-keeping practices varied widely, with many facilities lacking standardized registers, and reporting systems were fragmented or absent—particularly among private providers such as GPs. These gaps limit the availability of reliable, consolidated SRHR data for program monitoring and national reporting.

Objective

The project aims to establish a standardized and integrated system for recording and reporting FP, MR, PAC, and GBV services across all intervention facilities. By improving data quality and consistency, the initiative supports the integration of SRHR indicators into the national Health Management Information System (HMIS), ensuring sustainability and enabling evidence-based decision-making.

Approach and Key Interventions

1. Assessing Existing Systems

A comprehensive review of service delivery and data management practices was conducted across all intervention sites. This assessment highlighted gaps in documentation, inconsistencies in register use, and a lack of alignment with national reporting systems.

SRH Components	Record Keeping Practice found at the beginning of the project				Proposed Registers for Record Keeping & Recording Mechanism
	Referral Centers	UPHCSDP	Garment Clinics	General Practitioners (GPs)	
MR Services	Some have MR-PAC Register & some with no Register	**302_RH Register** and MR Register	No Register	No Register	**MR-PAC Register**
PAC Services	Some have MR-PAC Register & some with no Register	**302_RH Register** & **204_OT Register**	No Register	No Register	
Family Planning Services	Some have single Family Planning Register & some have FP method specific service registers	**302_RH Register** and FP method specific service registers	FP method specific service registers	No Register	**Unified Family Planning Register**
Gender Based Violence (GBV) Services	No Register	**305_VAW Register** & **407_VAW History Form**	No Register	No Register	**Update existing VAW Register**
Reporting Practice	DGHS HMIS (DHIS2), DGFP MIS	UPHCSDP HMIS (DHIS2), DGFP MIS, DGHS HMIS (DHIS2)	DGFP MIS	Nowhere	**Integration with National HMIS**

2. Standardizing Service Registers

To ensure uniformity, the project introduced government-approved registers across all facility types:

Family Planning Register

MR-PAC Register

VAW-GBV Register

These registers replaced fragmented and inconsistent tools, enabling standardized data capture across referral facilities, urban clinics, and garment factory clinics.

3. Digitizing Data Collection for Private Providers (general practitioners)

Recognizing the unique role of GPs, who typically operate outside formal reporting systems, the project introduced an app-based reporting system. Tablets and mobile applications were provided to trained GPs to record FP, MR-PAC, and GBV services digitally. This innovation reduced reporting burden and for the first time, brought GPs—previously outside any formal MIS—into the service reporting system.

App-based service recording and reporting by GPs

4. Strengthening DHIS2 and Aligning with National Systems

The project updated the Urban Primary Health Care Service Delivery Project (UPHCSDP) HMIS (DHIS2) platform by incorporating nationally approved indicators for FP, MR, and PAC services. This ensured alignment with the Directorate General of Health Services (DGHS) HMIS and strengthened interoperability.

Capacity Building

Extensive training was conducted to support system adoption:

- A total of **112** **urban health staff** received Training of Trainers (ToT) on new service registers and UPHCSDP HMIS (DHIS2) data entry.
- A total of **203** **service providers** across urban clinics, referral facilities, and garment clinics were trained on the unified national Family Planning Register.

These trainings improved providers' capacity to maintain accurate records, generate monthly reports, and align with national reporting formats such as DGFP MIS forms and DGHS HMIS (DHIS2).

Integration with National HMIS

Sustainability was a key focus of the initiative. The project worked closely with the Management Information System (MIS) Unit of the Directorate General of Family Planning (DGFP) to integrate SRHR data into national platforms, including:

- Service Statistics (SS)
- eMIS
- FP-DHIS2

List of MR, PAC and FP Indicators incorporated	DGHS HMIS (DHIS2)		DGFP MIS		UPHCSDP HMIS (DHIS2)	
	Before Intervention	*After Intervention*	*Before Intervention*	*After Intervention*	*Before Intervention*	*After Intervention*
Number of MR performed by Medication	√	NA	Not included	√	Not included	√
Number of MR performed by MVA	√	NA	Not included	√	Not included	√
Total Number of Menstrual Regulation (MR)	√	NA	√	NA	√	NA
Number of PAC performed by Medication	√	NA	Not included	√	Not included	√
Number of PAC performed by MVA	√	NA	Not included	√	Not included	√
Number of PAC performed by other procedure	√	NA	Not included	√	Not included	√
Total Number of Postabortion Care (PAC)	√	NA	√	NA	√	NA
FP Method Specific Postabortion FP (PAFP)	√	NA	Not included	√	Not included	√
FP Methods disaggregated by Client Types (Interval, PPFP, PAFP)	√	NA	Not included	√	Not included	√

Inclusion of MR-PAC and FP indicators into DGFP MIS and UPHCSDP HMIS (DHIS2)

Technical updates were made to reporting forms, data entry portals, and dashboards to incorporate FP and MR-PAC indicators. These enhancements were field-tested in public facilities before wider rollout, ensuring functionality and usability. This collaboration supports Bangladesh's transition toward a paperless, integrated HMIS, strengthening data-driven planning and decision-making across the health system.

Results

- Established uniform record keeping system: Facilities are using standardized service registers and reporting tools for FP, MR and PAC services
- Urban SRHR data is increasingly visible in national HMIS platforms
- Initiated the integration of GP services into the government service reporting system for the first time. Ongoing advocacy efforts aim to incorporate GP service data into the national HMIS, addressing the previous lack of inclusion in any HMIS.

Service Coverage

The strengthened HMIS contributed to improved service tracking and reporting, enabling the delivery of substantial SRHR services to urban populations during the project period:

Family Planning services: 594,851

MR-PAC services: 49,542

- MR cases: 16,993
- PAC cases: 32,549

GBV services: 11,450

Lessons Learned

- Engaging private providers requires flexible, low-burden digital solutions
- Standardization must be paired with hands-on training and system updates
- Government ownership is critical for long-term sustainability and scale-up

Conclusion

The Improving SRHR in Dhaka project demonstrates a scalable model for integrating urban SRHR data into national systems. By bridging gaps between public and private providers and aligning with government platforms, the initiative enhances data quality, accountability, and evidence-based planning. This approach ensures that no provider—and no client—is left out of the health system data ecosystem, strengthening Bangladesh's progress toward universal access to quality SRHR services.

Brief 7
Project Monitoring & Progress Tracking: Utilization of Service Provision Report (SPR), Client Exit Interviews (CEIs) and Facility Baseline and Endline Assessments

Introduction

The Improving SRHR in Dhaka project operates in a complex urban health landscape where service delivery spans public facilities, NGO clinics, garment health services, and private providers. Ensuring quality, accessibility, and responsiveness across such a diverse platform requires a robust and multi-dimensional monitoring approach. To effectively track progress and drive continuous improvement, the project utilizes three complementary data sources: Service Provision Reports (SPR), Client Exit Interviews (CEIs), and Facility Baseline and Endline Assessments.

SPR

- Conducted bi-annually at 65 facilities
- Tracks service quality indicators
- Identify gaps in service delivery

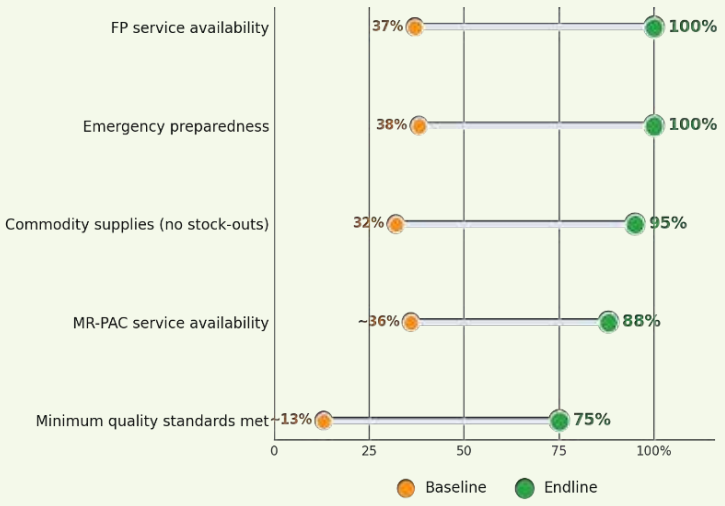
CEI

- Conducted annually which tracks trends over 3 rounds in sampled health facilities
- Measures privacy, counseling, client satisfaction and social support received
- Captures client's perception on FP, MR and PAC services

Facility Assessment

- Baseline vs endline comparison from 65 health facilities
- Measures facility readiness for FP, MR and PAC service provision
- Evaluates overall impact

Key Highlights from Facility Assessment- Measurable Success: Baseline vs Endline

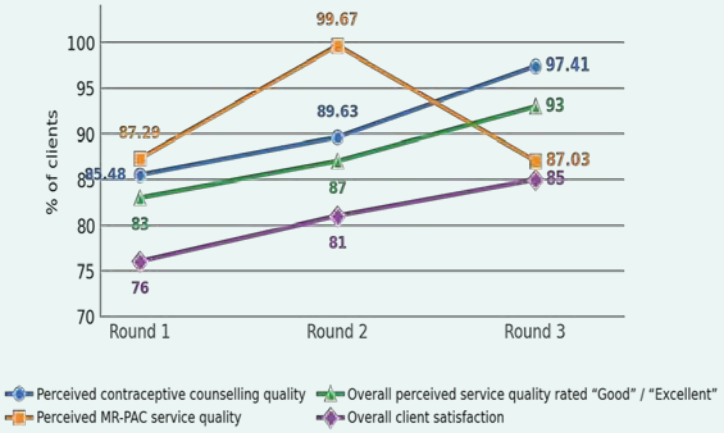


Beyond the numbers — project achievements

- WHO obsolete D&C procedure **eliminated** in supported facilities
- **91 GPs** providing FP service and **77 GPs** providing MR-PAC service *(from zero at baseline)*
- Standardized MR-PAC, FP, and GBV registers introduced across all facilities
- **100% timely reporting** achieved
- Digital reporting system introduced for GPs
- Urban Emergency Preparedness & Response Plan established

Key Findings from Client Exit Interviews — Perceived Quality & Satisfaction Across 3 Rounds

Figure 1: Clients perceived quality on SRH service received from 3 rounds of CEIs



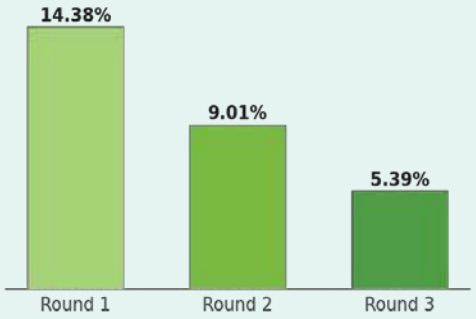
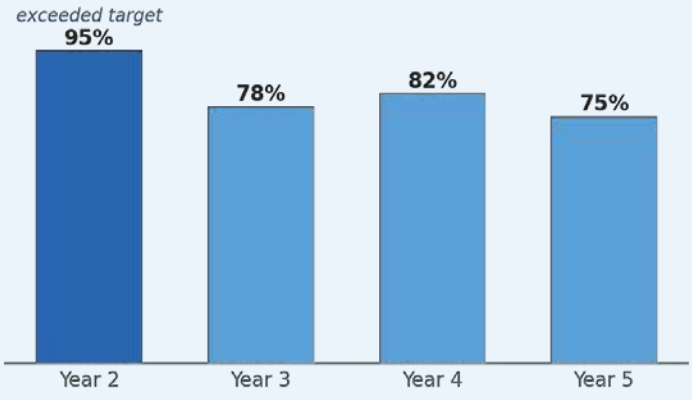


Figure 2: Clients below the poverty line fell from 14.38% to 5.39%, reach expanding beyond the poorest

What the trends tell us

- **Perceived Counseling quality—** marked improvement across all 3 rounds (85.48% → 97.41%), reflecting stronger client–provider communication.
- **Perceived MR-PAC quality —** consistently strong; a brief Round 3 dip was linked to privacy concerns in referral facilities.
- **Social support received —** stayed high (38.89 → 36.05 → 39.68), with emotional support the strongest dimension.
- **Service perception & satisfaction —** positive and sustained, with up to 93% rating the overall service quality as "Good" or "Excellent" and 85% reported satisfied with the service received.

Service Provision Report — Quality Performance & Service Delivery



Facilities meeting minimum quality standards, by year

Standardized quality assessment

- Measured against six indicators: privacy, appropriate technology, pain management, infection prevention, record keeping, and FP methods including LARC
- Majority facilities met at least **5 out of 6** indicators across project years

Recurring gaps identified

- Client privacy, FP method stock-outs, unsatisfactory record-keeping, occasional infection-prevention supply gaps

Continuous improvement & operational reality

- SPR findings drive corrective actions, targeted supervision and program adjustment
- Variation reflects diverse facility types (public, NGO, garment); focus is on progress and incremental improvement, not absolute compliance

Conclusion

Integrated use of SPR, CEIs, and facility assessments provides a robust monitoring system that drives measurable improvements in quality, access, and equity of SRHR services in Dhaka.

Brief 8
Emergency Preparedness for uninterrupted SRHR services in Urban settings

Background

Public health emergencies in Bangladesh, whether from pandemics or natural disasters, lead to higher morbidity and mortality, reduced access to sexual and reproductive health services, quality of care and increased risk of sexual and gender-based violence. Preparedness for Sexual and Reproductive Health and Rights (SRHR) in urban areas is crucial, ensuring continued access to family planning, miscarriage management, post-abortion care, and GBV services. Key strategies include deploying trained providers, pre-positioning supplies, and integrating commodities and supplies to maintain uninterrupted SRHR services.

Priority Risks to SRH Services Delivery

Utilization of SRH services may be altered or reduced during emergencies. Major impact include:

- Limited availability and inadequate emergency preparedness of healthcare providers.
- Disruptions in the supply of essential commodities, equipment, and adequately equipped facilities.
- Restricted access to health services due to movement barriers and service disruptions.
- Social stigma and lack of accurate information hinder timely care-seeking.
- Increased rates of adolescent pregnancies during lockdowns, as documented during COVID-19, increased risk of unsafe abortion and need for safe abortion and PAC

Objectives of Emergency Preparedness

- Improve availability and accessibility to quality SRH services for the underserved and vulnerable women and adolescents living in urban areas
- Improve public health emergency preparedness and responses to ensure access to and uninterrupted delivery of essential SRH services & supplies
- Develop contingency plans and tools to address the SRHR services during public health emergencies

Emergency Preparedness and Response Plans

Although early preparedness and response are critical to protecting the health of underserved women and adolescent girls during public health emergencies, no comprehensive national Emergency Preparedness and Response Plan (EPRP) existed for urban populations—especially for Menstrual Regulation (MR), Postabortion Care (PAC), and Family Planning (FP). Acknowledging the vulnerability of slum dwellers, low-income

residents, and gender-diverse groups, the Improving Sexual and Reproductive Health and Rights in Dhaka project, in collaboration with the Ministry of Health and Family Welfare (MOHFW), the Ministry of Local Government, and project partners, developed an Emergency Preparedness and Response Plan for urban areas to ensure uninterrupted access to essential SRH services and supplies during public health emergencies.

Contingency Plans

Contingency plans are action plans designed to overcome disruption and are developed based on the key risks and recovery strategies. Following Project Steering Committee decision chaired by the Secretary-MOHFW, a "Committee on Public Health Emergency Preparedness and Responses" led by the Director General of the Directorate General of Family Planning was formed. In February 2024, the committee reviewed the SRHR-focused urban emergency preparedness and response plan and drafted a contingency plan.

The Contingency Plans are focused on FP, MR, PAC and SGBV services. Recommended preparedness actions are:

- Stakeholder coordination at all levels
- Mapping of communities, infrastructure, providers
- Ensure available MR, PAC, FP, and SGBV providers for uninterrupted services
- SGBV prevention and risk mitigation
- Procurement of commodities, supply and storage
- Infection prevention and control;
- Referral system
- Community mobilization including utilization of digital platforms (social and mass media)
- Telemedicine services to ensure SRH services specially for MR and PAC service

SRHR Commodity Forecasting and Supply Chain Management

Commodity forecasting and supply chain management tools are developed by the project to meet the SRH needs of people living in Dhaka during an emergency. It is planned to engage the stakeholders early in the preparedness planning phase and designated some of the facilities to act as tertiary, secondary, primary and community level service delivery points, during emergencies. Government medical college hospitals should be the referral facilities for all.

All the designated facilities should be provided with necessary provider training and IEC materials. These health centers should preposition the essential SRH commodities, should have warehouse facilities and potential functional distribution chain. Sexual and gender-based violence management kits, also known as dignity kits, are also designed to provide immediate support.

Project Initiatives

Over the last 2 years, the country has had a huge shortage of FP commodities and logistics as government's procurement system was not working smoothly to procure FP commodities and logistics in a timely manner. Delays in the procurement of family planning commodities disrupted the consistent supply of SRH commodities at urban health facilities, ultimately affecting service coverage. Considering this situation as a public health emergency, and in response to requests from DGFP and local government bodies-Dhaka North, South and Narayanganj City Corporations, the project procured family planning and reproductive health commodities, along with necessary logistics and equipment, to ensure the uninterrupted delivery of SRH services at project-supported facilities.

Strategic Partnerships and Colaboration

A cornerstone of the Improving SRHR in Dhaka Project

The Improving Sexual and Reproductive Health and Rights in Dhaka Project is designed and implemented through a strong partnership approach involving government institutions, NGOs, city corporations, development partners, and private-sector stakeholders. Recognizing that sustainable improvements in urban health service delivery require coordinated action, the project prioritized collaboration among actors responsible for health and family planning services.

MoU with DGFP

MoU with BKMEA

MoU with UPHCSDP

MoU with Narayangonj City Corporation

Over the past five years, strong governance and collaboration have been central to the project's success. The Ministry of Health and Family Welfare and the Ministry of Local Government, Rural Development and Cooperatives provided strategic oversight through the Project Steering Committee and Project Technical Committee, ensuring policy alignment, accountability, and effective implementation. The active collaboration with UPHCSDP and Dhaka South and North City Corporation, and Narayanganj City Corporation further strengthened project implementation by promoting social accountability, local ownership, and institutionalization of best practices within urban primary healthcare systems.

Why Partnership and Collaboration..

- Project implementation
- Resource generation
- Technical support
- Sustainability

Transforming **100** GP chambers as quality SRHR service centers

Establishing SRHR services in **15** health centers of garment factories

Strengthening 38 Urban Health Centers to provide quality SRHR services

Strengthening **12** secondary and tertiary level facilities

Project Geographies

DNCC-83 facilities
- 19 UPHCSDP clinics
- 04 Referral Facilities
- 60 General Practitioners

DSCC-64 facilities
- 19 UPHCSDP clinics
- 05 Referral Facilities
- 40 General Practitioners

Gazipur-08 facilities
- 02 Referral Facilities
- 06 Garments factory clinics

Narayanganj-10 facilities
- 01 Referral Facilities
- 09 Garments factory clinics

Implementation sites: 165 facilities

Project Impact

594,851 clients received FP services

16,993 clients received MR services

32,549 clients received PAC services

11,450 SGBV cases documented and responded

1,068,428 community people mobilized through Outreach Workers and Youth Volunteers

1,755,868 people reached through social media

*Updated till March 2026

Acknowledgement

The project briefs are made from the experiences of Improving Sexual and Reproductive Health and Rights in Dhaka project. The evidence, lessons, and experiences shared through these briefs are a testimony to the dedication and hard work of government counterparts, healthcare providers, youth volunteers, General Practitioners, and implementing partners.

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