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IEO Independent Evaluation Office

Independent evaluation of the capacity of UNFPA in humanitarian action 2019–2025

Case Study

Bangladesh

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Acronyms and Initialisms

Abbreviation	Full Form
ANC	Antenatal Care
APRO	Asia Pacific Regional Office
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual Reproductive Health
A&Y	Adolescent & Youth
AWP	Annual Work Plan
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BMS	Bangladesh Midwifery Society
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERF	Central Emergency Response Fund
CMR	Clinical Management of Rape
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CO	Country Office
CWFD	Concerned Women for Family Development
DFID	Department for International Development (UK)
DGFP	Directorate General Family Planning (MoHFW)
DGHS	Directorate General Health Services (MoHFW)
DGNM	Directorate General Nursing and Midwifery (MoHFW)
DH	District Hospital
DHS	Demographic Health Survey
DSHE	Directorate of Secondary and Higher Secondary Education
DWA	Department of Women's Affairs
DYD	Department of Youth Development
EmOC	Emergency Obstetrics Care
EmoNC	Emergency Obstetrics and New Born Care
FGD	Focus Group Discussions
FP	Family Planning
GBV	Gender-Based Violence
GBViE	Gender-based Violence in Emergencies
GBVSS	Gender Based Violence Sub Sector
GE	Gender Equality
Acronym	Full Form
GEWE	Gender Equality and Women's Empowerment
GOB	Government of Bangladesh
GUK	GonoUnnayon Kendra
HPNSDP	Health Population and Nutrition Sector Development Plan
HR	Human Resources
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
IPs	Implementing Partners
ISCG	Inter-Sectoral Coordination Group
KII	Key Informant interviews
MCH	Medical College Hospital
M&E	Monitoring & Evaluation
MIS	Management Information System
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MoWCA	Ministry of Women and Children's Affairs
NGO	Non-Governmental Organization
PD	Population and Development
PWD	People with Disabilities
SOPs	Standard Operating Procedures
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health & Rights
STI	Sexually Transmitted Infection
TOR	Terms of Reference
UHC	Upazila Health Complex (DGHS)
UH&FWC	Union Health and Family Welfare Centre (DGFP)
UN	United Nations
UNCT	United Nation Country Team
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UN Women	United Nations Women
VAW	Violence Against Women
WB	World Bank
WFS	Women Friendly Space
WHO	World Health Organization

Introduction

The purpose of this evaluation is to:

- Assess and report on how the UNFPA capacity to prepare for and respond to emergencies has evolved based on the lessons learned and recommendations from the 2019 evaluation of the UNFPA capacity in humanitarian action (accountability).
- Draw lessons for UNFPA's present and future humanitarian action in view of the implementation of the next UNFPA strategic plan (learning).

The objectives of the evaluation are to:

a. Assess the relevance of UNFPA's humanitarian programming and, in particular, its ability to adapt to emerging changes in both the scale and nature of emergency responses worldwide and the related needs of different categories of affected people;
b. Assess the extent to which UNFPA's internal systems, processes, policies and procedures (in particular human and financial resources) allow for efficient and timely humanitarian action at all levels of the organization (global, regional, and national). progress on institutionalization and standardization of processes related to its SRHR and GBV inter-agency mandates, as well as UNFPA's approach on preparedness and pre-positioning of humanitarian supplies;
c. Assess the effectiveness as well as the coverage of UNFPA's humanitarian interventions, in terms of preparedness, anticipatory action, response to and recovery from humanitarian crises across different thematic areas (GBViE, SRHRiE, young people in emergencies, and data for humanitarian assistance etc.) and locations;
d. Analyze the extent to which humanitarian principles, humanitarian minimum standards, human rights, gender equality, disability inclusion, climate action, and social and environmental standards are integrated in UNFPA's humanitarian programming;
e. Analyze UNFPA's ability to strengthen the "resilience and adaptation, and complementarity among development, humanitarian and peace-responsive efforts" in line with the humanitarian-development-peace (HDP) nexus approach;
f. Propose recommendations for UNFPA's present and future humanitarian action.

The scope of the evaluation has the following dimensions:

- Geographically: All countries, regions, and globally, with a focus on all countries considered as "priority countries" by UNFPA since 2019.
- Thematically: All UNFPA strategies and programmes implemented in humanitarian settings.
- Temporally: From 2019 to the end of the data collection phase in 2024/2025.

The primary intended users of the evaluation are:

(i) UNFPA senior management;
(ii) The UNFPA Humanitarian Response Division;
(iii) Other UNFPA business units at headquarters;
(iv) UNFPA regional and country offices.

The results of the evaluation should also be of interest to a wider group of stakeholders, such as UNFPA Executive Board members and other United Nations organizations.

The purpose of this country briefing note is to complement the evaluation report with a standalone country-specific document (annexed to the evaluation report) that presents initial findings within the framework of the evaluation questions for Bangladesh.

Methodology

Evidence for this country note (both qualitative and quantitative) has been collected through a range of methodologies, including:

- Key informant interviews and group interviews with providers of services supported by UNFPA through its implementing partners (see Annex I for list of interviewees),
- Desk review of documentation (see Annex II for list of documentation reviewed),
- Community-based focus-group discussions (FGDs) (see Annex III for FGD methodology).

The country field visit was conducted in accordance with the United Nations Evaluation Group (UNEG) *Norms and Standards for Evaluations*, the UNEG *Ethical Guidelines for Evaluations*, the UNFPA *Country Programme Evaluation Handbook*, and the WHO *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*, and with adherence to the following principles:

- *Consultation* with, and participation by, key stakeholders
- *Methodological rigor* to ensure that the most appropriate sources of evidence for answering the evaluation questions are used in a technically appropriate manner
- *Technical expertise and expert knowledge* to ensure that the assignment benefits from knowledge and experience in the fields of gender-based violence (GBV) and sexual and reproductive health and rights (SRHR)
- *Independence* to ensure that the findings stand solely on an impartial and objective analysis of the evidence.

The Bangladesh country field mission was conducted from 23-28 March 2025 by the evaluation team member, Jeanne Ward. The mission included interviews with institutional stakeholders, partners and UNFPA staff in Dhaka and in Cox's Bazaar. A total of over 70 key informants and 25 FGD participants with affected populations were conducted. To achieve this number, many of the key informant interviews were conducted with groups. Given the timeframe for the evaluation and the extensive country program, there was less time available for consultations with affected populations, particularly in Cox's Bazar. For a full list of key informants, see Annex I. The schedule of interviews and visits is presented in Annex III.

Background

Bangladesh Country Context

Population and Demographics

The People's Republic of Bangladesh is a South Asian nation bordered by India to its north, west, and east, Myanmar to its southeast, and the Bay of Bengal to its south. With an estimated population of over 175 million in 2025, it ranks as the eighth most populous country globally. The country is administratively divided into eight divisions and 64 districts. While a significant portion of the population still resides in rural areas, urbanization is increasing, with over 42% of the population living in urban centers. Dhaka, the capital and largest city, is a megacity with a population exceeding 15 million.[1]

Bangladesh faces challenges associated with its large population density, including pressure on resources and infrastructure. The country has made strides in poverty reduction and improvements in health and education in recent decades, although challenges persist, such as climate change vulnerability, political instability, and the need for further economic diversification.

Demographically, Bangladesh has experienced a significant reduction in its total fertility rate since its independence. The current total fertility rate is around 1.9 children per woman, which is below the replacement level.[2] The median age in Bangladesh is approximately 26 years, indicating a relatively young population. Life expectancy at birth has improved over the years and is around 74 years.[3]

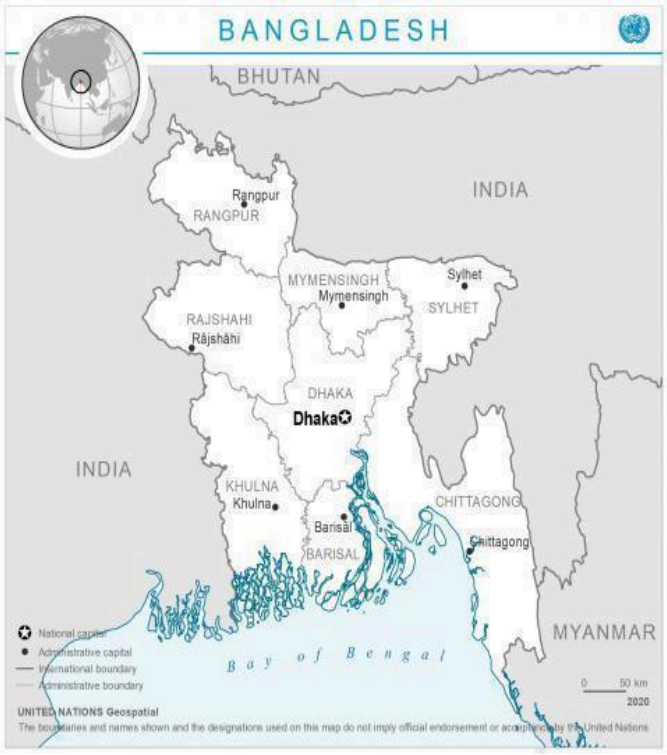

Figure 4 Map of Bangladesh[4]

The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Governance

While nominally a parliamentary democracy, the political landscape is often shaped by a history of intense rivalry between the two major parties, the Awami League and the Bangladesh Nationalist Party, with periods marked by protests and political violence. Currently, the country is navigating a transition following

[1] https://www.worldometers.info/world-population/bangladesh-population/
[2] https://www.macrotrends.net/global-metrics/countries/BGD/bangladesh/fertility-rate
[3] https://www.worldometers.info/demographics/bangladesh-demographics/
[4] https://www.un.org/geospatial/content/bangladesh-0

significant political upheaval and a student-led movement to oust the Prime Minister from the Awami League party in 2024, resulting in an interim government led by Nobel Laureate Muhammad Yunus tasked with steering the nation towards new elections.[5] The key challenges for the government include addressing entrenched corruption, undertaking crucial institutional and electoral reforms, and managing the demands of various political forces, including the resurgence of Islamist parties, all while striving to maintain stability and pave the way for a credible democratic process.

Humanitarian Context

The humanitarian situation in Bangladesh is complex, marked by the world's largest refugee settlement of Rohingya from Myanmar in Cox's Bazar who are prohibited by the government from working and are therefore heavily reliant on aid.[6] Bangladesh is also highly susceptible to recurrent natural disasters like cyclones and floods, leading to cyclical internal displacement.[7] The country's ongoing and coordinated efforts to address humanitarian needs are briefly summarized below.

Cox's Bazaar

In August 2017, over 750,000 Rohingya fled to Bangladesh following violent military crackdowns in Myanmar's Rakhine State. They joined previous influxes of Rohingya who fled the country in the 1970s and 90s. Today, more than one million Rohingya refugees live in Bangladesh, most of them in Cox's Bazar district, near the border with Myanmar.[8]

The humanitarian response in Cox's Bazar is led and coordinated by the Government of Bangladesh. The government established the National Task Force (NTF), chaired by the Ministry of Foreign Affairs (MoFA), to provide oversight and strategic guidance. The Refugee Relief and Repatriation Commissioner (RRRC), under the Ministry of Disaster Management and Relief (MoDMR), is responsible for the operational coordination of the refugee response at the District level. The Deputy Commissioner (DC) in Cox's Bazar District also plays a crucial role in coordinating the response for host communities and ensuring security.

Strategic guidance and national-level engagement by the humanitarian community, including UN agencies and international and national NGOs, is provided by the Strategic Executive Group (SEG) in Dhaka, co-chaired by the Resident Coordinator, UNHCR Representative, and IOM Chief of Mission. Coordination amongst the UN agencies in Dhaka level is done through the framework called UN Rohingya Response (UNRR). At the operational level in Cox's Bazar, there is the Refugee Operations and Coordination Team (ROCT) where UNFPA is an observer. The Senior Coordinator of the Inter-Sector Coordination Group (ISCG) Secretariat ensures overall coordination, liaising with the RRRC, DC, and other authorities. The ISCG convenes the Heads of Sub-Offices Group (HoSOG), ROCT, inter-sectoral Coordinators Group.[9]

The Joint Response Plan (JRP) outlines the needs, response strategies, and financial requirements of the humanitarian community. As discussed further in the findings, development actors like the World Bank and Asian Development Bank(ADB) also provide significant support in Cox's Bazar, often aligning with the priorities identified in the JRP.

National Disaster Response

Bangladesh is one of the world's most disaster-prone countries, with a high risk of exposure to a wide range of natural hazards. Its unique geography—as a low-lying river delta with an extensive coastline—makes it particularly vulnerable to climate- and weather-related events. The Global Climate Risk Index 2021 ranked Bangladesh as the 7th most vulnerable country to climate disasters. In the period covered by the evaluation (2019 to 2025), Bangladesh has experienced repeated disasters, including cyclones (Amphan, 2020; Sitrang, 2022; Mocha, 2023; Hamoon, 2023; Remal, 2024; Dana, 2024), monsoon flooding (2019, 2020, 2022, 2024) and flash floods (2022, 2023, 2024). These events, exacerbated by the effects of climate change, caused widespread morbidity and mortality, infrastructure damages, economic losses, displacement, disruption of education, and destruction of livelihoods.

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[5] https://www.crisisgroup.org/asia/south-asia/bangladesh/bangladesh-dilemmas-democratic-transition. Also see https://southasianvoices.org/pol-c-bd-n-bangladesh-in-2024-12-19-2024/

[6] https://www.unhcr.org/countries/bangladesh

[7] https://www.worldbank.org/en/country/bangladesh/overview

[8] Unfpa_annual_report_2022_01_25_05_2023.pdf

[9] Bangladesh_Cyclone-Mocha-Flash-Appeal_May-Dec-2023.pdf

To manage its ongoing exposure to disasters, Bangladesh has evolved a comprehensive multi-tiered disaster response structure, primarily governed by the Disaster Management Act of 2012[10] and guided by the Standing Orders on Disaster (SOD, updated most recently in 2019)[11], the National Disaster Management Policy 2015[12] and the National Plan for Disaster Management (NPDM) 2021-2025.[13] The focus has increasingly shifted towards proactive risk reduction and preparedness, alongside emergency response and recovery mechanisms. Key national structures in disaster management include:

- **National Disaster Management Council (NDMC):** This is the apex body for disaster management, headed by the Prime Minister. It is responsible for formulating and reviewing disaster management policies and issuing directives. The NDMC includes various ministers and high-ranking government officials and receives expert advice from the National Disaster Management Advisory Committee (NDMAC), headed by an appointee of the Prime Minister.
- **Ministry of Disaster Management and Relief (MoDMR):** This is the lead ministry responsible for coordinating disaster management and relief efforts. It formulates policies, allocates budgets, and oversees the implementation of disaster management programmes. Agencies under this ministry include the Disaster Management Directorate (DMD), the executive arm of the MoDMR, responsible for implementing disaster management policies and programmes, and the Cyclone Preparedness Programme (CPP), a joint initiative of the Government of Bangladesh and the Bangladesh Red Crescent Society (BDRCS), focused on early warning systems and community-based disaster response programmes for cyclones that involves a large network of volunteers who disseminate warnings, assist in evacuations, provide first aid, and conduct search and rescue operations.
- **Inter-Ministerial Disaster Management Coordination Committee (IMDMCC):** Chaired by the Minister of MoDMR, this committee implements the policies and decisions of the NDMC and coordinates disaster management activities across all government agencies. Disaster Management Committees (DMCs) are also cascaded to various administrative levels to coordinate and implement disaster management activities at the local level. These committees include representatives from government agencies, local administrations, NGOs, and community members, reflecting a “whole of society approach” laid out in the NDPM 2021-2025.
- **Humanitarian Coordination Task Team (HCTT):** Co-chaired by the Secretary of MoDMR and the UN Resident Coordinator, this task team was formalized in the SOD in 2019 and is typically activated when the scale of a disaster exceeds the national and local capacities for response, ensuring a coordinated international effort to complement the government response. The HCTT leads the development of the HRP for the disaster and supports anticipatory action for preparedness and early response.
- **Inter-cluster coordination group (ICCG):** The Inter-cluster Coordination Group (ICCG) in Bangladesh serves as a collaborative platform, comprising of various national level clusters and working groups, with a mission to enhance nationally led initiatives in the fields of risk reduction, preparedness, early warning, anticipatory action and response, in line with humanitarian principles. The national cluster coordinators and working group coordinators are members of this group. The ICCG is chaired by the Humanitarian Advisor from the Resident Coordinator’s Office.
- **National clusters:** Sectoral and thematic coordination platforms of relevant government and non-government humanitarian actors, including NGOs, CSOs, UN agencies and IFRCs/BDRCS. The national clusters are part of the Government Standing Order on Disaster (SOD) 2019. Currently there are ten national clusters (food security, WASH, shelter, education, child protection, health, nutrition, displacement management, logistics and GBV) and six thematic / technical working groups (anticipatory action, accountability to affected population, gender in humanitarian action, cash working group, needs assessment working group and information management working

[10] https://disasterlaw.ifrc.org/media/3293?language_content_entity=en

[11] https://file-chittagong.portal.gov.bd/uploads/6b9a9df8-2650-4326-bbfd-55418d77e00d//681/9ce/7cb/6819ce7cb0a3f332539892.pdf

[12] https://modmr.gov.bd/sites/default/files/files/modmr.portal.gov.bd/policies/d95dd631_9f63_4ac1_8229_a606ec84fb54/Published%20DM%20Policy%202015.pdf

[13] https://modmr.portal.gov.bd/sites/default/files/files/modmr.portal.gov.bd/page/a7c2b9e1_6c9d_4ecf_bb53_ec74653e6d05/NPDM2021-25%20DraftVer5_23032020.pdf

group). The national clusters are co-chaired between a cluster lead UN agency and relevant Government ministry - e.g. the Gender based violence cluster is co-chaired between UNFPA and the Ministry of Women and Children Affairs (MoWCA). The clusters are responsible for undertaking strategic coordination in disaster preparedness, anticipatory action and emergency response in respective sectors.

UNFPA Bangladesh Country Office

UNFPA began its operations in Bangladesh in 1974. Since 2017, there has been a dedicated humanitarian specialist to oversee UNFPA's response to disasters. There is also a humanitarian unit dedicated to lead and coordinate disaster response and preparedness, which works with the wider humanitarian team consisting of humanitarian focal points of each programme unit based in Dhaka, Cox's Bazar and other field officers.

There is a sub-office in Cox's Bazar with Head of Sub Office (HoSo), a humanitarian coordinator and GBV, SRH and A&Y coordination, operations (to include administrative, finance and logistics) and programme staff, as well as operations staff that facilitate UNFPA's refugee response.

For its disaster response efforts, UNFPA's work is structured around successive Country Programme Documents (CPDs), with the 9th (2017-2021) and 10th (2022-2026) CPDs being relevant to this review. The total indicative budget for the 9th CPD was USD 52.6 million,[14] and for the 10th CPD it is USD 68.5 million.

Both these CPDs focus on four key outcome areas: Sexual and Reproductive Health and Rights (SRH), Adolescents and Youth (A&Y), Gender Equality and Women's Empowerment (GEWE, including attention to GBV), and Population Dynamics (PD). They are designed to align with the Government of Bangladesh's (GoB) five-year plans and the overarching UN development frameworks in the country. UNFPA's 10th CPD also reflects adjustments from the 9th CPD based on recommendations from the 9th CPD evaluation including, for example:

- While recognizing the work on A&Y initiated for the refugee response, the evaluation noted that A&Y outcomes generally suffered in the 9th CPD due to funding delays and recommended scaling up interventions like Life Skills Education (LSE)/Comprehensive Sexuality Education (CSE) and supporting the relevant ministry. The 10th CPD explicitly mentions making life skills education available for out-of-school youth a focus area.
- The evaluation recommended strengthening engagement on data, addressing data gaps, and harmonizing data. The 10th CPD explicitly highlights strengthening engagement on all aspects of data and increasing the use of disaggregated population data for policy and planning.
- The evaluation suggested incorporating men and boys into GBV prevention and recognizing their vulnerabilities. The 10th CPD explicitly mentions incorporating boys into gender-based violence prevention interventions.
- The evaluation recommended bridging the humanitarian-development divide. The 10th CPD emphasizes its investment in delivering innovative solutions across the humanitarian-development continuum.

The 10th CPD is currently being evaluated. As noted previously, the purpose of this briefing note is to contribute to the global humanitarian evaluation. Nevertheless, the results of this Bangladesh country-level review will be shared with the CO to support the 10th CPD evaluation.

For Cox's Bazaar, UNFPA's humanitarian response efforts are organized according to a Joint Response Plan (JRP) described further below.

[14] This is for development action and disaster response. The total assistance for CP9 (including the refugee response) was USD$156,038,673.

Findings

EQ1 (Relevance/Appropriateness) To what extent do UNFPA's humanitarian strategy and programmes correspond to the identified needs of affected populations, including the needs of the marginalized and vulnerable groups, while remaining aligned with the UNFPA mandate?

Findings:

1. **While the current (10th) CPD for Bangladesh (2022-2026) departs from the previous CPD's humanitarian commitments insofar as it does not reference refugee response, there is significantly increased attention to disaster preparedness and response and UNFPA's commitment to working across the humanitarian-development continuum in the 10th CPD.**
2. **UNFPA mandate areas are integrated within the annual Joint Response Plans for the Rohingya refugee crisis as well as in national policy/planning and appeals documents for disaster response, including CERF appeals for anticipatory action funding.**
3. **UNFPA is involved in and leads a variety of needs assessments that promote engagement of marginalized groups and support access to services for specific marginalized populations.**

Finding 1: While the current (10th) CPD for Bangladesh (2022-2026) departs from the previous CPD's humanitarian commitments insofar as it does not reference refugee response, there is significantly increased attention to disaster preparedness and response and UNFPA's commitment to working across the humanitarian-development continuum in the 10th CPD.

The 9th CPD for Bangladesh (originally designated for 2017-2020, and extended for one year due to the COVID-19 pandemic) contained reference to humanitarian response, with a focus on delivery of SRH and GBV services to populations affected by emergencies, including refugees.[15] The country programme evaluation (CPE) of the 9th CPD underscores UNFPA's contributions in this area, with many references to its investments in the Rohingya refugee response.[16] Notably, however, the 10th Country Programme (2022-2026) explicitly excludes commitments directly related to the Rohingya crisis, noting that refugee response programming is addressed under the Joint Response Plan.[17] The UN Sustainable Development Cooperation Framework (UNSDCF), which guides the CPDs of UNFPA and other UN agencies, does not include the Rohingya response, in accordance with the directive given by the Government of Bangladesh.

In other aspects, the priorities and design of the 10th CPD were informed by findings and recommendations of the 9th CPE, notably for this review in relation to work on disasters, building institutional capacity of partners, and intensifying work on GEWE. A key shift with reference to humanitarian engagement from the 9th to 10th CPD is from a focus in the 9th CPD largely on facilitating SRH and GBV response in humanitarian emergencies to scaling up work across the humanitarian-development continuum in the 10th CPD and prioritizing alignment with the GoB commitments to the Sendai Framework for Disaster Risk Reduction. Also distinct from the 9th CPD, the 10th CPD highlights innovation and innovative approaches. These areas are explored further below under relevant evaluation questions.

While there is no specific humanitarian output in the 10th CPD,[18] there is explicit recognition throughout Bangladesh's high risk of exposure to climate-induced shocks. The 10th CPD references the humanitarian-development continuum and disaster preparedness and response under the SRH, Gender and A&Y outcome areas, as well as specific strategies to build out UNFPA's comparative advantage in working across the continuum, such as through government partnership and capacity building. The GEWE outcome area stands out insofar as it distinctly references work in development and humanitarian settings alongside references to disaster and climate-affected communities. There is no reference to humanitarian action

[15] https://www.unfpa.org/sites/default/files/portal-document/N1620634.pdf
[16] https://www.unfpa.org/evaluation-unfpa-9th-country-programme-assistance-government-bangladesh#
[17] https://bangladesh.unfpa.org/sites/default/files/pub-pdf/cpd_bgd_10_-_bangladesh_cpd_-_final_-_18jul21.pdf
[18] According to a UNFPA key informant, at the time of CPD approval, the new Strategic Plan, including the addition of a new output on humanitarian response, was also being approved by the Executive Board. As both documents' approval processes occurred simultaneously, the Country Programme Results Framework was aligned with the previous Strategic Plan, and the new output was not reflected. However, to ensure continued investment in humanitarian response and its development-humanitarian nexus, a dedicated indicator on MISP was included.

(including climate action or disaster preparedness and response) under the population dynamics outcome area.[19]

The language within the 10th CPD of working across the continuum provides an important basis for generating resources to implement disaster preparedness and response activities. It also reflects the CO's commitment to improving links between UNFPA humanitarian and development planning, processes and staffing as discussed further in EQ8. Notably, however, several key informants from UNFPA (at least one of whom was involved in the development of the 10th CPD for Bangladesh) expressed concern that the meaning of the humanitarian-development continuum is not specifically defined within the 10th CPD document, nor elsewhere in country guidance. As a result, even if UNFPA key informants have largely "embraced a mindset of working at the nexus,"[20] several interviewees from UNFPA felt it was not always clear what specific targets of this work are (or should be) in Bangladesh.[21]

Finding 2: UNFPA mandate areas are integrated within the annual Joint Response Plans for the Rohingya refugee crisis as well as in national policy/planning and appeals documents for disaster response, including CERF appeals for anticipatory action funding.

In the **Rohingya response**, UNFPA participates in the annual JRP process, which is led by the ISCG in Cox's Bazar and is based on joint needs assessments (JNAs). In the earlier years of this review (2019-2020), UNFPA's advocacy to the ISCG for the JRP was focused on establishing foundational, life-saving SRH and GBV services in the immediate aftermath of the large-scale refugee influx.[22] As the crisis became protracted, advocacy shifted towards ensuring the sustainability, quality, and comprehensive nature of these services, with greater attention to the needs of youth.[23] UNFPA's leadership in coordination mechanisms for SRH, GBV and youth—discussed further below-- has contributed to its ability to ensure attention to its mandate areas in the JRP. For example, UNFPA's leadership of the SRH Working Group in the Health Cluster enables UNFPA to advocate for the inclusion of essential SRH services, including maternal and newborn health, family planning, and STI treatment, into the overall health sector response outlined in the JRPs.[24] In addition, UNFPA's investment in data gathering in Cox's Bazar response (e.g. from information management systems, programme monitoring to specialized evaluations) has contributed to its ability to advocate for continued, evidence-based interventions within the JRPs.[25] In just one example provided by a UNFPA key informant, the analysis of family planning service uptake in the camps has helped determine that service distribution is working, leading to its continuation and informing resource requests.

However, several UNFPA key informants acknowledged that funding for UNFPA mandate areas has been consistently less than other sectors. While it is difficult to track specific funding for SRH through the OCHA Financial Tracking System,[26] Financial tracking for health more generally and for Protection and GBV (where data is available) across the years covered in the review confirm that funding has been lower than for other sectors.[27]

In its **disaster response** at the national level,[28] UNFPA advocacy and positive relationships with government partners has resulted in improved attention to SRH and GBV in national disaster response

[19] According to a UNFPA key informant, while the PD Unit actively supports data needs for humanitarian preparedness and response, including in climate-related contexts, these areas are not currently reflected in the PD outcome or ToC due to the timing of the ToC's development in 2020 for the 10th CP, when a scoping exercise found no specific demand from humanitarian or climate change data. As a result, these dimensions were not formally integrated into the PD framework. However, this role has evolved over time. In 2024, work on CODs initiated under the lead of RCO, with the PD Unit providing demographic and UNFPA-mandated data. A dashboard was also developed and shared accordingly.
[20] UNFPA Key informant.
[21] Working at the nexus in Bangladesh has been defined with the broader HCTT Nexus Strategy,
[22] UNFPA Key informant, also see 2019 and 2020 JRPs.
[23] UNFPA Key informant.
[24] UNFPA and External UN Key informants.
[25] UNFPA Key informant. See for example, https://bangladesh.unfpa.org/sites/default/files/pub-pdf/2024-10/SRH%20survey%20Broucher%20%20%284%29.pdf; https://rohingyaresponse.org/wp-content/uploads/2024/09/PS-Joint-Protection-Monitoring-Report-2024-Quarter-2.pdf
[26] This is because SRH funding is not separate from the tracking of overall health funding.
[27] See https://fts.unocha.org/plans/1143/summary
[28] Throughout this document, distinction is made between the refugee response, and the response to natural disasters. Notably, however, disaster response is implemented for refugee populations so the distinction is for analysis in this report of the two specific humanitarian areas of response, which overlap in practice.

strategies, such as in the Nexus Strategy (2021-2026) for climate disaster response,[29] as well as the Ministry of Health and Family Welfare's (MOHFW) National Adaptation Plan for climate change.[30] While not specific to emergencies, a nevertheless significant achievement is the integration of the MISP into the operational plan of the government's Maternal, Newborn, Child, Adolescent Health programme (under the Directorate General of Health Services/DGHS), as well as government leadership to conduct national MISP readiness assessments and integration of the MISP into the 5th operation plan.[31]

UNFPA's mandate areas are also systematically integrated into Humanitarian Response Plans (HRPs), Humanitarian Needs Overviews (HNOs), and appeals for funding. This integration is facilitated by UNFPA's strategic positioning within the disaster response architecture. UNFPA is a member of the HCTT representing its own mandate as well as a cluster lead agency, and within that, of the Needs Assessment Working Group (NAWG), led by the Department of Disaster Management (DDM) and CARE Bangladesh, which undertakes JNAs and Rapid Needs Assessments (RNAs).

In addition, UNFPA co-leads the GBV Cluster at the national level with the Ministry of Women and Children's Affairs (MoWCA) as well as the national SRH Working Group under the Health Cluster with the MoHFW.. Through the GBV information management specialist, UNFPA participates in the Information Management Working Group (IMWG) co-led by the Bangladesh Bureau of Statistics (BSS) and the RC's office under the HCTT.

UNFPA also participates in the Anticipatory Action Technical Working Group (AATWB), alongside other UN agencies including FAO, UNICEF, and WFP. Several external key informants noted the importance of UNFPA's presence in this working group and the agency's significant success in ensuring attention to UNFPA's mandate areas are included in CERF funding for anticipatory action.[32] According to one external key informant, UNFPA is "very well informed about CERF mechanisms and frameworks...they advocate very well to CERF for their cause."[33] UNFPA's work on anticipatory action is discussed further under EQ8, below.

UNFPA's mandate areas of GBV and SRH have their own sector response plan summaries (under an "Integrated GBV and SRH" sector) in many of the HRPs and HNOs developed for disaster response during the review period (2019-2024), such as the Cyclone Amphan Response Plan (2020)[34]; the Monsoon Floods Response and Recovery Plan (2020-2021)[35]; and the Flash Floods Humanitarian Response Plan (2022).[36] In other response plans, UNFPA is identified as the lead in GBV, and SRH is covered under the health sector and in WASH (e.g. the Cyclone and Monsoon Floods HRP 2024[37] and the Chattogram Flash Floods 2023[38]). For the Cyclone Mocha Flash Appeal,[39] GBV is included under Protection for the Rohingya Response and SRH under Health (in line with the sectors established for the refugee response) but is an integrated SRH and GBV sector for the Mocha response coordinated by the HCTT.

Some common components included in these response plans are distribution of baby kits for pregnant women; deployment of midwives at government health facilities/mobile SRH health services for the MISP; distribution of menstrual health management (MHM) kits and, mobile SRH health services for the MISP; distribution of menstrual health management (MHM) kits and dignity kits; awareness raising, and GBV case management and PSS. Increasingly cash voucher assistance is integrated into HRPs for dignity items, transport, assistive devices/improved treatment support for women/girls with disabilities, Menstrual Health and Hygiene (MHH) and to prevent child marriage. Adolescent and youth issues tend to be integrated across sectors. Adolescent health is specifically noted in the 2024 Cyclone and Monsoon Floods HRP, the 2020 HCTT Monsoon Floods HRP and the 2020 HCTT Cyclone Ampham HRP. However, adolescent and youth

[29] There are specific references to SRH and GBV in the strategy. See https://rohingyaresponse.org/wp-content/uploads/2023/05/HCTT-NEXUS-STRATEGY-2021-2025-Humanitarian-Development-Collaboration-for-Climate-Related-Disasters-in-Bangladesh.pdf

[30] Reference in UNFPA's 2022 Annual Report

[31] Govt Key Informant. Planning is currently underway for the scale-up of MISP implementation throughout the most vulnerable districts around the country as part of the fifth operational plan, which is expected to start implementation in July 2025.

[32] UN Key Informants.

[33] UN Key Informant.

[34] UN. Bangladesh Coordinated Appeal. Cyclone Amphan Humanitarian Response Plan Jun -Sept 2020.

[35] UN. Bangladesh Coordinated Appeal. Monsoon Floods Humanitarian Response Plan Jul 2020-March 2021.

[36] UN. Bangladesh Coordinated Appeal. Flash Floods Humanitarian Response Plan Jul-Dec 2022. 2022

[37] UN. Bangladesh Cyclone & Monsoon Floods Humanitarian Response Plan. Jun 2024- Dec 2024

[38] UN. Chattogram Division Flash Floods and Monsoon Rain. HCTT Humanitarian Response Plan 2023. Aug 2023-Jan 2023

[39] UN. Bangladesh Cyclone Mocha Flash Appeal. May-Dec 2023

issues are underrepresented in other response plans, such as the 2019 HCTT Monsoon Floods.[40] Although UNFPA mandate areas are generally well-integrated into HRPs for disaster response in Bangladesh, the level of funding for interventions was repeatedly raised by UNFPA and external key informants as a hindrance to coverage and effectiveness, even in terms of anticipatory action. In one example, the HRP update (covering June 2024 to March 2025) for the Cyclone and Monsoon Floods indicated that GBV had received $2M of its $7.7M request, and health (including SRH) had received $791K or its $8M request.[41] Funding issues are explored further in subsequent sections. These funding challenges are not specific to these response areas, but rather reflect the overall low funding rates for these appeals.

Finding 3: UNFPA is involved in and leads a variety of needs assessments that promote engagement of marginalized groups and support access to services for specific marginalized populations.

In general, UNFPA is very involved in inter-sectoral needs assessments for both refugee and disaster response. UNFPA also conducts its own assessments linked to its mandate areas. Data regularly collected and consolidated by UNFPA (such as through beneficiary profiling, accountability to affected populations (AAP) frameworks, information management systems and post-distribution assessments) informs response planning and resource mobilization for thematic areas.

For example, in **Cox's Bazar** in 2024, UNFPA reviewed questions and indicators in the Inter Sector Needs Assessment (ISNA) related to GBV, SRH and youth, and supported training for the ISNA enumerators to ensure they understood the assessment questions and their research approach was safe and ethical.[42] . This included piloting the questions with members of the refugee community prior to the mass data collection. At the programmatic level, engagement with beneficiaries is standard in the planning process, as well as in monitoring. UNFPA has in the last several years conducted surveys on MHPSS with adolescents and youth,[43] as well as menstrual health management (MHM),[44] to establish baselines that can be used to inform future assessments and monitoring. UNFPA also utilizes surveillance, and various information management approaches (GBVIMS, SRH dashboard).[45] UNFPA increasingly reports disaggregated data on persons with disabilities in its assessments and monitoring for example, utilizing guidance and support from a UNFPA Disability Inclusion Specialist to undertake Vulnerability and Infrastructure GBV Assessment in 2021.[46]

For **disaster response**, UNFPA programming is based on assessed needs through mechanisms like NAWG. In addition, UNFPA Bangladesh's Standard Operating Procedures for Humanitarian Response Operations (2023) -- widely recognized by staff as a critical tool for facilitating and standardizing the CO's engagement in disaster readiness, response and recovery actions -- specifically notes UNFPA's key needs assessment responsibilities:

- Verify data received from secondary sources, as well as review data from multi-cluster and sectoral assessments;
- Deploy a rapid needs assessment team and/or participate in inter-agency needs assessment;
- Draft preliminary scenario;
- Gather, analyze and integrate SRH and GBV impact data/info into NAWG Joint Assessment Report.[47]

In another example of how UNFPA has embedded its obligations for ensuring humanitarian needs of its target populations are met, the Terms of Reference for the National GBV Cluster, co-led by UNFPA and MoWCA, states one of its responsibilities is to "work with relevant entities to ensure that key GBV concerns are reflected in multi-sectoral assessments, as well as other non-GBV specific sectoral assessments."[48] UNFPA staff may be included in these assessments and/or the review of the assessment reports, (e.g.,

[40] See https://reliefweb.int/report/bangladesh/bangladesh-humanitarian-response-and-recovery-plan-monsoon-floods-august-2019
[41] See https://reliefweb.int/report/bangladesh/bangladesh-cyclone-and-monsoon-floods-humanitarian-response-plan-june-march2025?_gl=1*1sy0wau*_ga*MTkwODEwNzI5Mi4xNzQ5Njc1NDI3*_ga_E60ZNX2F68*czE3NDk2NzU0MjYkbzEkZzAkdDE3NDk2NzU0MzYkajUwJGwwJGgw
[42] UNFPA Key Informant.
[43] See https://bangladesh.unfpa.org/sites/default/files/pub-pdf/mhpss_survey_-_summary_of_findings_3.pdf
[44] See https://bangladesh.unfpa.org/sites/default/files/pub-pdf/2025-03/Menstrual%20Health%20Brochure_08.pdf
[45] See for example, Sexual and Reproductive Health Working Group Bulletin: Rohingya Refugee Response, Cox's Bazar. January – December 2023.
[46] UNFPA Key Informant. Also see https://projects.hpc.tools/project/196397/view
[47] UNFPA SOP for Humanitarian Response Operations
[48] Bangladesh-Terms of Reference-Gender Based Violence (GBV)-21-12-2023.pdf

NAWG Monsoon Flood 2020 Preliminary Impact Assessment,[49] Cyclone YAAS JNA[50]). PPR also contributes to these assessments by providing demographic profiles and data on vulnerabilities to help identify affected populations and inform targeted interventions.[51]

The success of UNFPA in drawing attention to specific vulnerabilities and needs related to UNFPA's mandate areas is evidenced in many Bangladesh disaster assessment reports. For example, the Cyclone Amphan JNA notes increased vulnerability to GBV, child labor, child marriage, and human trafficking due to livelihood loss.[52] Monsoon flood assessments referenced above report disruption of nutrition care, ANC/neonatal care services, and difficulties in maintaining personal and menstrual hygiene.[53] Flash flood assessments, also referenced above, highlight damaged health facilities impacting maternal health and GBV response, increased risk of child marriage, and vulnerability of adolescent girls to GBV.[54] Cyclone Remal assessments note the potential worsening conditions for pregnant women, disruption of health services, increased risk of GBV, vulnerabilities of adolescent girls including MHM lack and risk of early marriage, and specific vulnerabilities and needs of PWD and transgender and other gender-diverse groups.[55]

In addition to participation in joint needs assessments, UNFPA field officers communicate with local governments before disasters to understand the situation and vulnerability of communities to inform their own specific programme intervention.[56] They also conduct a review of facilities to assess capacity for response in the affected areas. Further, UNFPA uses ongoing engagement with DGHS (as a development partner) to support SRH response in emergencies, including consultation with health authorities at the local district and national levels.[57] According to a UNFPA staff, this regular engagement has allowed them to transition away from a “top-down” approach to determining needs, to a “bottom-up” approach.

> *We consult with the local level and then district level health authority and the beneficiaries, to find out what they really need. So it's not like we do a regular assessment, but rather during our routine development SRH intervention, we come to really know what they need during the disaster. For example, we came to know that RH kits might not be very effective because the government now has the capacity in the district facilities to provide a moderate level of supplies, so we supply the baby kits which have never been supplied.*[58]

In some instances, after the disaster UNFPA undertakes its own missions to assess needs. According to a key informant:

> *We do have joint missions to the field with our thematic focal person, and we collect information related to UNFPA mandate areas...and we capture that information in project proposals.*[59]

Several examples of how UNFPA has utilized needs assessments and other data to adapt and innovate its programming in order to address specific needs of marginalized groups emerged during the KIIs; these include introducing cash for dignity items for specific disasters; targeting transgender/gender diverse individuals and sex workers with SRH and PSS support; cash support to purchase assistive device for adolescent girls with disability, disability inclusive MHM kits, distributing MHM kits to adolescent girls, including those with disabilities through government facilities such as schools, union parishads and other

[49] See https://reliefweb.int/report/bangladesh/bangladesh-monsoon-floods-2020-coordinated-preliminary-impact-and-needs-assessment
[50] https://reliefweb.int/report/bangladesh/cyclone-yaas-light-coordinated-joint-needs-analysis-needs-assessment-working-group
[51] UNFPA Key informant.
[52] UN. Bangladesh Coordinated Appeal. Cyclone Amphan Humanitarian Response Plan Jun -Sept 2020.
[53] See for example UN. Bangladesh Coordinated Appeal. Monsoon Floods Humanitarian Response Plan Jul 2020-March 2021.
[54] See for example UN. Chattogram Division Flash Floods and Monsoon Rain. HCTT Humanitarian Response Plan 2023. Aug 2023-Jan 2023
[55] UNFPA. Bangladesh Cyclone Remal Response Plan. 2024
[56] UNFPA Key Informant.
[57] Govt Key Informant, UNFPA Key Informant.
[58] UNFPA Key Informant.
[59] UNFPA Key Informant.

relevant institutions[60] modifying distribution items for ethnic communities; and using conditional cash support to prevent child marriage for at-risk households. One external key informant summarized UNFPA's value:

> *UNFPA is very instrumental in terms of reaching disadvantaged and vulnerable groups, like transgender groups… And the sexual and reproductive health--whoever has those needs, and also the youth, adolescent, and, of course, the pregnant and lactating mothers, supporting all those things. Those are very crucial. Other organizations are not working on those aspects, so UNFPA's work is actually very much instrumental and also beneficial to vulnerable people.*[61]

Despite good evidence of assessment of needs of affected populations, external key informants recommended several areas for improvement in UNFPA's assessment processes, particularly in disaster response where the timeframe for needs analysis is more limited than in the ongoing refugee response. In disasters it is standard practice for UNFPA to use preexisting SRH and other data to assess needs, alongside the MISP calculator to help estimate, quantify and subsequently budget assistance required. However, two external key informants noted that the MISP calculator is based on outdated census data.[62] Moreover, several of these key informants felt that there should be more consultation with affected populations prior to the disaster, rather than in post-distribution assessments and beneficiary profiling after the disaster. According to one UNFPA key informant, immediately after a disaster strikes, UNFPA does not have *"specific tools to assess people…rather we look at geographic location and district."*

While UNFPA staff suggested that they do reach out to populations affected by disaster (when there is no emergency) as part of their development work and this provides useful information about populations needs, several other external key informants felt that UNFPA should conduct more regular pre-disaster consultations and more directly involve vulnerable populations in preparedness planning.[63] In one example, the lack of consultation with affected populations reportedly resulted in UNFPA distributing pre-packaged baby kits that were not felt to be appropriate to the setting.[64] (Notably, these kits were adjusted through subsequent consultations with recipients.)

[60] In terms of disabilities, one key informant noted the value of a disabilities training in 2023 provided by UNFPA APRO, which helped UNFPA scale up attention to PWDs in its assessments. In 2024, UNFPA led a consultation in Dhaka with Organizations of Persons with Disabilities (OPDs) and individual people with disabilities to support more adaptive design to MHM kits.
[61] UN Key Informant.
[62] INGO Key Informants.
[63] INGO Key Informant and FGD participants.
[64] FGD participant.

EQ2 (Effectiveness/Coverage) To what extent do UNFPA humanitarian interventions contribute to an improved access to and increased use of quality sexual and reproductive health services for affected populations, including the most vulnerable and marginalized groups?

Findings:

4. **UNFPA's programming in Bangladesh significantly aims to provide quality SRH services and commodities in humanitarian response, with efforts focused on accessibility and the specific needs of vulnerable populations. However, the extent to which these services consistently meet quality and accessibility standards across all affected areas varies.**
5. **Utilization of a broad range of quality SHR services has improved in Cox's Bazar and to a lesser (but still important extent) in acute disasters during the review period.**

Finding 4: UNFPA's programming in Bangladesh significantly aims to provide quality SRH services and commodities in humanitarian response, with efforts focused on accessibility and the specific needs of vulnerable populations. However, the extent to which these services consistently meet quality and accessibility standards across all affected areas varies.

UNFPA has had success in ensuring delivery of a wide range of SRH services and commodities in Cox's Bazar, not only to refugees, but also the host community. From as early as 2017, UNFPA invested in ensuring basic SRH services for refugees were established. Over time, UNFPA has expanded services and continues to invest in building capacity of service providers and improving accessibility and availability of both services and commodities. Commodities also continue to be a major focus: Pre-positioned supplies include reproductive health kits, medicines and dignity kits. According to one internal key informant, UNFPA covers almost 90% of the SRH commodities across the response in Cox's Bazar.[65]

Through approximately eleven UNFPA direct IPs as well as 30+ additional coordination partners (international, local, and GoB) participating in the SRH working group, a range of SRH services are provided at various health facilities and protected spaces like Women Friendly Spaces (WFS). In recent years, a major focus of UNFPA and its partners has been the operationalization of the GoB Family Planning Strategy for Rohingya Refugees (2022-2025), aiming to strengthen access to safe, voluntary family planning, including long-acting methods, at both facilities and community levels, supported by commodity procurement and distribution to partners.[66] According to several key informants external to UNFPA, the agency has worked well with the government to promote the government's Family Planning Strategy, while also supporting the rights, choices, dignity and needs of refugee women and girls in relation to SRH services.[67] One external key informant stated, "*I think UNFPA has done an excellent job at managing those sensitivities and political dynamics in a difficult policy context.*"[68]

UNFPA also supports maternal and newborn care, most recently emphasizing improvements to strengthen comprehensive emergency obstetric care (CEmONC) and newborn care by supporting the restoration of 24/7 services and implementing Maternal and Perinatal Mortality Surveillance and Response (MPMSR) systems. UNFPA also supports the Emergency Referral Transport Service (ERTS), or "Matri Sheba," providing referrals for obstetric and newborn emergencies across the camps, alongside a community shuttle system for scheduled appointments.[69]

In addition, UNFPA has scaled up adolescent SRHR services, notably through the establishment in 2022 of programmes within eight Adolescent and Youth Centers that integrate SRH information and services and life

[65] UNFPA Key Informant.
[66] See https://bangladesh.un.org/en/219478-launch-family-planning-strategy-rohingya-refugees
[67] The GoB has been criticized for using coercion to press women into using contraceptives to keep the Rohingya birthrate low. See https://www.thenewhumanitarian.org/investigations/2025/05/29/rohingya-women-coerced-use-contraception-bangladesh-refugee-camps. UNFPA and other UN agencies through the JRPs emphasize a rights-based approach to addressing refugee need.
[68] Donor Key Informant.
[69] Sexual and Reproductive Health Working Group Bulletin: Rohingya Refugee Response, Cox's Bazar. January – December 2023.

skills sessions that incorporate SRH and GBV.[70] Clinical Management of Rape (CMR) services are also provided at all UNFPA-supported health service centers, often integrated with GBV case management in health facilities and with midwives in Women Friendly Spaces.

UNFPA contributes to the capacity building of health practitioners and community health workers to deliver safe and comprehensive SRH and GBV services, supporting a network of Community Health Workers who disseminate SRH information. UNFPA is also supporting midwifery-led enhanced cervical cancer and obstetric fistula screening and management. One external key informant flagged UNFPA's international midwife mentors as a good practice, one that was initially limited to UNFPA partners but later expanded to SRH WG partners because it was so successful.[71]

Another key innovation by UNFPA in addressing SRH needs and mitigating GBV risks has been the use of Cash and Voucher Assistance (CVA). In the early phase of the Rohingya response—around the first quarter of 2018—UNFPA piloted a cash support initiative for pregnant women to encourage antenatal care (ANC) visits and facility-based deliveries. While the cash approach initially helped reduce financial barriers, field learnings and protection concerns led to a strategic shift. To reduce potential risks of cash-related gender-based violence and to enhance the effectiveness of the support, the initiative transitioned into an e-voucher system. Through this system, pregnant women receive electronic vouchers redeemable at approved outlets for essential nutritional items. This shift improved accountability, enabled better monitoring, and ensured more direct and safer support for maternal nutrition—contributing to healthier pregnancy outcomes in a dignified and protected manner.

When disasters impact Cox's Bazar, UNFPA, as the SRH Working Group Chair, plays a pivotal role in leading the response through the implementation of the MISP. By prepositioning RH kits in advance, UNFPA ensures that IPs and working group partners have the necessary resources available during crises. UNFPA also supports the deployment of IP mobile medical teams to reach remote and underserved areas, providing essential services during disaster response.

Despite the significant progress UNFPA has made in scaling up SRH services to refugees, a report in 2024 of the SRH Working Group within the Rohingya response areas of Ukhia and Teknaf identified a number of service delivery limitations in different health facilities , such as in midwifery led care; diagnostic tools; family planning commodities (due to stockouts); privacy and sex-segregated facilities; and inconsistent adherence to national and international SRH guidelines. Following the Joint Monitoring and Assessment, the SRH Working Group started to take targeted actions to improve service quality through its Quality Improvement Technical Team, led by UNFPA's Quality Assurance Analyst. The team provides individualized feedback and technical support to partner organizations, facilitates capacity-building initiatives, and ensures equitable distribution of essential SRH commodities to strengthen service delivery across the response. A follow-up assessment is planned for 2025 to track progress and guide further improvements.[72]

In addition, funding for SRH continues to be an issue. One UNFPA staff person in Cox's Bazar noted that in 2024,

> *The SRH thematic area was underfunded by almost 40% last year. If you look at the JRP trends, last year was better for UNFPA, because by the end of the year, we were 81% funded. But that hides the differences among the units. SRH remains consistently the most underfunded unit in UNFPA in Cox's Bazar.*

During **disaster response**, UNFPA's programmatic priority is to implement the MISP. Essential commodities such as RH kits, dignity kits and MHM kits are procured and stored centrally and locally to ensure faster delivery and distribution during disasters. UNFPA and external key informants noted that in the past, it had been difficult to convince funders that addressing SRH (and GBV) are life-saving interventions, but that UNFPA advocacy has led to more widespread acknowledgement of this.[73] One result of this advocacy (as well as of UNFPA building out its procurement and delivery systems) is how significantly UNFPA has

[70] These centers are explicitly noted as initiating from the expressed needs of the Rohingya youth themselves, who desired a place that belonged to them where they could feel heard, safe, and learn.
[71] UN Key Informant and UNFPA Key Informant.
[72] SRH Joint Monitoring Report
[73] UNFPA and Government Key Informants.

improved its distribution capacity in recent years. According to one key informant, " *In 2017 we maybe only had 500 distributions of dignity kits—but we mobilized more that 3 million in 2024*."[74] UNFPA's involvement in anticipatory action has been one important reason for this improved response, discussed further in EQ7.

In addition, in the last several years, UNFPA strengthened its focus on integrating the MISP into routine practices and preparedness plans at the district level.[75] UNFPA is providing midwifery support and MHPSS support to Union Health and Family Welfare Centers at the community level, as well as training on GBV referrals to health staff. UNFPA also supports mobile SRH health camps where possible. Volunteers are recruited to provide community sensitization on SRH and referrals, with one success noted that UNFPA has facilitated an increase in the number of women taking on these volunteer positions.[76]

UNFPA and external key informants suggested that a key gap in disasters related to UNFPA mandate areas is in SRH staffing and technical support, particularly to address newborn and maternal child health, but also capacity of midwives who can be deployed in disasters, and who have the skills to detect high-risk mothers as part of antenatal care.

> *We need readiness at sub-centers so midwives can provide services. This is very crucial because people are not going to hospitals.*[77]

These challenges are related to issues of recruitment by GoB. In 2023, UNFPA collaborated with MOHFW to innovate a certificate course on climate change and health, with a focus on sexual and reproductive health and rights. The course was successfully piloted at Dhaka University, the largest public university in Bangladesh.[78] A key informant indicated that almost 2,600 midwives have been deployed in the upazila health complexes and union level facilities, with around 3000 midwives in the process of deployment by the government; these midwives can support SRH care during emergencies. . However, the same key informant suggested that the level of demand requires significant additional training, such as through online trainings, with materials in Bangla.[79]

Additionally, UNFPA has supported CVA in disaster response, – such as for dignity items; for MHM, including to address menstrual poverty for adolescents; and cash to help pregnant women access care--reflecting the preferences of affected people and utilizing mobile money networks (discussed further in EQ7). Consultations with affected communities, including special needs groups like transgender individuals and sex workers, have informed the approaches to cash assistance and increased the utility of the approach.

However, challenges persist in the provision of SRH services in disasters. Rapid needs assessment and UNFPA annual reports detail how transportation challenges, financial constraints, damaged health facilities, and lack of delivery facilities pose significant barriers to accessing care during and after disasters.[80] Low uptake of ANC even during normal times in some affected districts exacerbates vulnerabilities in emergencies. Moreover, volunteers may not receive sufficient training to meet the demands of their outreach work.[81] And, as noted previously, ongoing resource limitations mean UNFPA can support only a "minimal number" of the affected community.[82]

Data from UNFPA's humanitarian dashboard for 2023 reinforces this finding. The table below provides the overall people in need as the base denominator, and the number of people targeted as a % of that.[83] This analysis aims to highlight the differences in people reached and people targeted / people in need.

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[74] UNFPA Key Informant.
[75] Key informant.
[76] IP Key informant.
[77] Govn Key Informant.
[78] UNFPA 2023 Annual Report.
[79] Govn Key Informant.
[80] UNFPA 2022 Annual Report.
[81] FGD participants.
[82] UNFPA Key informant.
[83] All data is from https://www.unfpa.org/data/dashboard/emergencies. Bangladesh data on the dashboard does not separate refugee response from national disaster response. However, in KIIs, the issue of reaching people in need vs those targeted by UNFPA came up specifically for disaster response, not refugee response.

People in Need	UNFPA People targeted	% UNFPA target of people in need	People reached with SRHR services/information	People reached with GBV services/information	% UNFPA people reached against people targeted (GBV+SRH)
14,150,526	1,013,547	7%	313,182	681,224	98%

Although UNFPA has had success in meeting its own coverage targets for humanitarian response, its services only reach a small percentage of the people in need. While UNFPA cannot be held accountable for all coverage needs, the limited reach was noted by several key informants. One summarized:

> *When we are talking about life saving intervention, and when there is an emergency, MISP is integrated as part of this SRH response. But when we are doing response, sometimes we feel it is undermined in terms of funding. Compared to other domains, like food security or Nutrition, SRH is very tiny amount. We are really able to reach a very teeny portion of the population. So that's why, compared to the funds which we receive and the amount of response we need to do, there is a certain disparity.*[84]

Finding 5. Utilization of a broad range of quality SHR services has improved in Cox's Bazar and to a lesser (but still important extent) in acute disasters during the review period.

There is evidence to indicate that supported interventions have led to increased access and utilization of SRHR services, in turn contributing to improved health outcomes of affected and marginalized populations in humanitarian settings.

For example, in the **Rohingya response,** a World Bank evaluation cited by a UNFPA key informant and conducted in 2022, found that the number of women and girls seeking family planning commodities was five times higher in Women Friendly Spaces (WFS) supported by UNFPA in comparison to the health facilities. According to a UNFPA key informant, this was because the WFS are seen as a "safe space where they can come and privately ask for supplies." The proportion of adolescents accessing FP services from the WFS has been persistently increasing - as per the SRHR service database (see chart below).

YEAR	Number of adolescents who received voluntary FP from	
	Health facilities	WFS
2020	40%	60%
2021	34%	66%
2022	24%	76%
2023	28%	72%
2024	31%	69%
Total	**32%**	**68%**

Source: UNFPA SRHR Service Database

Another UNFPA key informant noted that after the introduction of a family planning strategy developed by the government with support from UNFPA and the SRH Working Group, and implemented using community-based approaches, there was a massive surge in family planning uptake among the Rohingya population. An SRH survey undertaken in 2024 showed that contraceptive prevalence rates (CPR) increased

[84] UNFPA Key Informant.

significantly from almost 33% in 2021 to 55% in 2024 among the Rohingyas. The uptake of long-acting reversible contraceptives (LARCs) also multiplied. Adolescent pregnancies among the Rohingya population fell from 18% in 2019 to 7% in 2024, which was described as a "huge impact level" result.[85]

Data from the SRH Working Group monitoring in Cox's Bazar suggests there have also been improvements in facility deliveries, with a total of 33,854 facility-based births in 2023, an increase from 27,240 reported in 2022. By December 2023, facility-based deliveries for the Rohingya response were 85% of the total deliveries (community and facility-based), showing a small, but noticeable increase from 81% in December 2022. Another achievement in April 2023 was a CEmONC facility becoming fully operational 24/7. This single facility performed an average of 202 caesarean sections per month by the end of 2023, which is higher than the previous response-wide monthly average of 115. As the only CEmONC center in the camp, it receives referral cases from all PHCs across the camp, serving a population of over one million Rohingya refugees. Given the center's referral role and the population it serves, the number of caesarean sections performed aligns with the anticipated caseload of complicated pregnancies requiring surgical intervention in such a humanitarian context.[86]

Finally, while maternal deaths in the refugee camps remain a major challenge, there has been a gradual decline in the number of deaths, from 84 in 2021 to 46 in 2024.[87] This is linked to efforts including the maternal and perinatal mortality surveillance system and expert review committees. One external key informant summed up UNFPA's success:

> *I think the results they achieved are very impressive. If you compare some of the data from Rohingya communities to host communities, particularly around child marriage, the use of family planning and contraceptives, even family size, what they've achieved over eight years is really impressive and benchmarked really well against host communities.*[88]

With respect to **disaster response**, a UNFPA IP interviewee acknowledged that before 2019, SRH services were "very neglected" by the government-led response. However, UNFPA's advocacy for an increased focus on SRH during disasters has raised awareness and understanding among community members and government officials of its importance.[89] In turn, there has been increased uptake of SRH services where they are rolled out in disasters (reiterating, as above, that coverage remains an issue). For example, following the deployment of midwives and provision of essential logistics and supplies in formerly low-performing or non-functional Union-level facilities after a disaster, there has been a significant increase in deliveries at those facilities. Data from the SRH response to flash floods in 2022 suggests that a total of 1,213 safe deliveries were conducted by skilled midwives during the 9 months of the project period--a significant increase compared to only 120 deliveries in the same facilities in the 9 months prior to the intervention.[90] This increase is also seen in other SRH services such as ANC, Postnatal Care (PNC), and family planning services and counseling in the supported facilities.

According to a UNFPA key informant, data from the response after Cyclone Remal showed that midwives working in 16 Union level health facilities conducted 330 deliveries within four months, compared to a baseline of only 83 deliveries in those same facilities over the previous six months. Moreover, referrals for maternal complications increased by 319% (from 43 to 180 women). The increased access and utilization of services, particularly through the deployment of midwives and community engagement, have led to a significant increase in referrals of women with complications to higher-level facilities, directly saving lives.[91]

The mobile SRH health "camps" (clinics that bring services to the community) have also supported uptake of services, even to some of the most marginalized populations. For example, in Cyclone Remal, UNFPA planned to mobilize 20 mobile camps[92]; for the eastern floods in 2024 UNFPA planned for 15 mobile

[85] https://bangladesh.unfpa.org/sites/default/files/pub-pdf/2024-10/SRH%20survey%20Broucher%20%20%284%29.pdf
[86] Sexual and Reproductive Health Working Group Bulletin: Rohingya Refugee Response, Cox's Bazar. January – December 2023.
[87] UNFPA Key Informant.
[88] UN Key Informant.
[89] Govn Key Informant.
[90] Response to Northeastern Flash Floods 2022.
[91] UNFPA IP Key informant.
[92] EF 514 Cyclone 2024.

camps[93]; and for the 2023 Chattogram Flash Flood UNFPA planned for 30 mobile camps.[94] Each mobile SRH camp supported by UNFPA reaches approximately 100-150 women and girls, especially targeting excluded communities, sometimes giving people, including pregnant women, the opportunity to access SRH services for the very first time. This has led to outcomes such as the first-ever institutional delivery from a particular excluded community. One interviewee noted that " *community feedback from the services was very much satisfactory.*"[95]

Other interventions contributing to access and uptake include the distribution of essential kits and cash assistance. Examples of distribution include 16,000 dignity kits during the 2022 northeastern flash flood response,[96] 2,000 Dignity Kits and RH kits distributed in Bhola and Barguna districts during Cyclone Sitrang,[97] and initial distributions for Cyclone Remal including 1,000 dignity kits, 1,307 MHM kits, and 200 Baby kits from prepositioned stocks.[98] However, several key informants noted that distribution of food items—such as dry biscuits, rice, dry milk, etc.—alongside kits would better meet their needs (suggesting an opportunity for increased coordination with sister agencies, discussed in EQ7).[99]

Another significant issue with the delivery of SRH services in disasters is the sustainability of services after the disaster response has ended. According to one UNFPA key informant, UNFPA advocates at national and local levels for the retention of midwives deployed to emergencies in non-functional or least-functional facilities to ensure service continuity after the short-term project support ends. UNFPA is also striving to address SRH staffing shortages through training and capacity building noted above. However, one external key informant stated emphatically that "*after a disaster, there is no support for SRH…When the project is finished all are gone*."[100] Another similarly noted that after projects stopped, services reverted to their previous state, "*But now that they have stopped the project there, it's again back to the same situation (of limited availability of SRH service*s)."[101]

[93] EF 536 2024 Floods.
[94] HRP Chattogram Flash Floods 2023.
[95] UNFPA IP Key Informant.
[96] UNFPA 2022 Annual Report
[97] UNFPA 2022 Annual Report
[98] EF 514 Cyclone 2024
[99] FGD community volunteer participants.
[100] UNFPA IP Key Informant.
[101] FGD participant.

EQ3 (Effectiveness/Coverage)To what extent do UNFPA humanitarian interventions contribute to preventing, mitigating and responding to gender-based violence and harmful practices for affected populations, including the most vulnerable and marginalized groups?

Findings:

6. **UNFPA and partners have made notable and ongoing contributions to the quality and effectiveness of GBV response in Bangladesh's humanitarian crises.**
7. **Uptake of GBV services in humanitarian crises in Bangladesh has improved, particularly in the refugee response, but also for disaster-affected populations.**

Finding 6. UNFPA and partners have made notable and ongoing contributions to the quality and effectiveness of GBV response in Bangladesh's humanitarian crises.

As noted previously, and to be discussed further in EQ5, UNFPA is responsible for the overall coordination and leadership for addressing GBV in both refugee response and disasters in Bangladesh. In Cox's Bazar, UNFPA has led the GBV Sub-Sector since 2017. At the national level for disaster response, UNFPA co-leads the national GBV Cluster with MOWCA. This leadership on GBV has been instrumental in ensuring GBV is recognized as a life-saving intervention in humanitarian action in Bangladesh.[102] Importantly, UNFPA's 10th CPD includes the humanitarian context and the development-humanitarian nexus for GBV work, providing a mandate for these activities.

For the **refugee response**, in the initial years of the response, UNFPA prioritized setting up services, within its thematic focus areas. The focus gradually moved on to expanding services and monitoring and improving quality of care. UNFPA GBV operations are extensive, supporting the delivery of GBV services through 21 UNFPA-supported health facilities and 55 women-friendly spaces (WFS) across 33 camps in Cox's Bazar.[103] One indicator of the scope of the GBV response is the JRPs: In 2024, 755,625 people of concern were targeted for protection and GBV services, of which 562,517 were refugees and the remaining from the host community, discussed further below.

In health facilities, health providers have been trained in the provision of CMR services, as well as on other GBV issues such as intimate partner violence (IPV), which is consistently the highest reported GBV issue in Cox's Bazar.[104] GBV specialized caseworkers are also placed in some of these health facilities to support psychosocial services and referrals for survivors for whom health services are their first point of entry for care.

Another important pathway for survivor care is the WFS—where only women and girls have access to GBV case management and referrals. In the 2023 JRP, GBV case management is identified as a "firewalled" or critical activity within the response—meaning that it is a high priority for funding. UNFPA supports training and mentoring for case management staff. The WFS' also offer SRH services, socialization activities and life skills development, including for A&Y.[105] Notably, during COVID, UNFPA-supported WFS were the only ones left open because integration of SRH and GBV was considered a priority activity; this enables continuity of services for women girls, particularly CMR and FP.

As noted in EQ1 Finding 3, there are many strategies that UNFPA IPs employ to support AAP and generate feedback from women and girls using the WFS. As a result, the WFS have evolved over time. For example, the reconstruction of the WFS gutted by fire in camp 9 responded to the women's stated needs by featuring a bathing cubicle, offered alongside a midwife room, session rooms for case management and PSS, and a voucher shop for dignity items.[106] This last intervention—allowing women to use vouchers to purchase their preference of dignity items—is a simple yet innovative adaptation to dignity kit distribution

[102] UN Key Informant.
[103] CERF Proposal, Dec 2023.
[104] See GBVIMS quarterly reports.
[105] As noted previously, there are also stand-alone A&Y centers where GBV, SRH and life skills programming is provided to youth, and where youth are engaged in determining and leading on programming that meets their needs.
[106] UNFPA Key Informant.

that promotes user choice and independence. Adhering to the building back better strategies, the WFS that are reconstructed post disasters have incorporated inclusive design elements, such as access for persons with disabilities.

In the last several years--and also in response to community feedback--UNFPA supported Women Led Community Centers (WLCC), where both men/boys and women/girls have access, and GBV prevention initiatives such as *SASA!* facilitated. This is a novel strategy to ensure that women still have access to women-only spaces through WFS', without pressure to include men—especially in the camps where resistance from male community members to women-only spaces can be a factor. Framing the WLCC as a place that is inclusive of both males and females, but at the same time focusing on GBV prevention work, supports the continuation of transformative GBV work that WFS are meant to facilitate, but also may help to reduce some of the backlash against WFS.

However, FGDs with IPs—particularly those working in WLCCs-- seemed to indicate some confusion about the fact that GBV survivor services should specifically target women and girls because of their heightened risk of exposure to certain forms of violence. Global GBV AoR guidance makes it clear that GBV service providers can and should facilitate referrals for male survivors to MHPSS service delivery points and/or health centers. However, this is not the responsibility of GBV service providers. Some representatives of IPs interviewed for the evaluation did not seem clear on this point, nor did they appear to have a strong conceptual understanding of GBV as violence against women and girls that is based in gender discrimination—which is especially important in highly patriarchal communities where there is resistance to transformative gender norms change.[107]

Data from a UNFPA 2023 project proposal indicated UNFPA at that time was covering 73% of GBV service facilities and leading in preventive, risk mitigation and response activities in 82% of the service locations, including refugee camps and host communities.[108] Despite the breadth of women's empowerment and GBV-related services supported by UNFPA, sources indicate ongoing challenges, specifically:

- Service access barriers due to the security context and interference from local authorities or perpetrators,[109]
- Funding limitations impacting staffing and service availability,[110]
- Limited service availability during nights and weekends,
- Difficulties for (or reluctance of) survivors to access MHPSS when co-located in health centers.[111]

Another challenge raised by external key informants is the issue of coordinated referral mechanisms among protection partners, particularly the need to ensure refugees can receive referrals and access support for different protection needs, across different protection service-delivery points.[112] One external key informant reported that their organization felt that organizational territorialism undermined referrals for assistance to women and girls beyond the WFS and WLCCs.[113]

Yet another issue related to service delivery is the consistently high decline rates for services like safe shelter and legal assistance, presumably due to the distrust of authorities.[114] The limited availability of shelter and legal services is also a matter of concern. Across the response there are no more than two formal shelter homes and a number of informal shelters within the communities. Limited partners provide legal assistance; moreover, it is complex for the refugee community to access the services. Notwithstanding these challenges, since 2024 UNFPA has been piloting the integration of legal assistance services in three of the WFS it supports.

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[107] UNFPA IP Key Informants.
[108] See https://projects.hpc.tools/project/161945/view
[109] See GBVIMS annual reports, for which these are ongoing issues. These concerns were also raised by key informants as a significant source of stress for IPs.
[110] 2023 JRP GBVSS, GBVIMS Factsheet 2024
[111] 2023 GBVIMS Annual Report
[112] UN Key Informants.
[113] According to a UNFPA key informant, to mitigate this a joint referral pathway across the protection sector - outlining Protection, GBV and CP referral services per camp-- was developed and made public in 2024. Service providers were also trained, including GBV service providers on " caring for child survivors," and CP frontline service providers on GBV case management.
[114] In the 2023 Q! GBVIMS report noted, "Safe shelter, legal assistance, police & security services are being declined by the majority of the survivors. Despite requiring these services, the rate of decline is high as availing these services is lengthy and complex and even most of the survivors prefer to live in abusive relationships/marriages to avoid further harm and GBV risk."

The most recent GBVIMS (Q1 2025) Bulletin notes that the US Government funding freeze had a profound effect on GBV actors, leading to disruptions in service delivery across eight camps and two host communities:

> *Women and Girls' Safe Spaces (WGSS) in Camps 5, 13, 14, 15, 16, 18, 22, 25, and other GBV service points were either closed or operated on reduced schedules. Due to suspended staff contracts, operational facilities were limited to providing Psychological First Aid (PFA) and referrals. To mitigate the risks associated with this disruption, GBVSS partners are engaging with donors to reprioritize activities. Additionally, the GBVSS has coordinated with unaffected partners who stepped in to continue service provision in the affected camps. The GBVSS also collaborated closely with the ISCG to map the affected areas, and the resulting gap analysis was shared with donors to support advocacy and mobilize a timely response.*[115]

In an innovative approach that is relevant to UNFPA globally, UNFPA in Cox's Bazar previously worked with the World Bank on an integrated GBV and SRH project that served both refugees and host communities and represented a collaborative relationship with the GoB in supporting refugee response while also improving GBV and SRH services for the host community. At the time of the assessment, UNFPA was at the last phases of negotiating new projects for SRH and gender with the World Bank. These new projects have a significant split (almost 50/50) of funding between Rohingya refugees and host communities, building on the previous World Bank funding which was largely for refugees (80/20 split). The funding for the Rohingya refugees will be available as a grant, whereas those for the host communities shall be loans.

This World Bank funding is seen as a key part of the shift towards an "area- based response" in Cox's Bazar, integrating humanitarian and development efforts.[116] UNFPA's appeal includes $17.5 million for gender work for the Rohingya communities and 2.5 million as part of the loan component for the host communities. Similarly for SRH, the appeals constitute $14.7 million for the Rohingya refugees and $0.5 million for the host communities in Ukhiya and Teknaf as the grants component, and $1.7 million from the loan component to support the health facilities and community health centers around the broader Cox's Bazar and Noakhali host communities.

UNFPA's GBV services in **disaster response** specifically target vulnerable women and girls, including adolescent girls, persons with disabilities, and sexual and gender diverse populations. Interviews with UNFPA and IP key informants suggest that in the last several years, there has been a shift from GBV response being primarily dignity kit distribution to including a broader range of services. This assertion is exemplified in UNFPA's annual internal CO humanitarian preparedness plans, which highlight UNFPA's prioritized anticipatory and rapid response actions for upcoming disasters. Resource allocation for disaster-related GBV programmes has also increased significantly since 2022, including through strategic engagement in funding mechanisms such as anticipatory action.

Strengthening referral networks is a key part of UNFPA's work on GBV in emergencies, to ensure survivors' referral to essential health and social services (and available legal services, based on survivors' wishes). Since the COVID-19 pandemic, UNFPA has supported the flagship
Alapon helpline, which provides counseling and referrals for SRH, GBV, and MHM, primarily for adolescents and youth but also serving adults. UNFPA has also deployed counselors to the 109 government hotline, which provides support and referrals to survivors and those at risk of GBV.

UNFPA has championed the development and implementation of GBV case management, working towards models that are social service and MHPSS-led, moving beyond a primary focus on police response. For example, UNFPA has trained and supported MHPSS counselors and case workers to provide GBV case management services in government facilities in disaster-affected areas, where one government interviewee noted there is a huge demand.[117] UNFPA has also trained community volunteers on GBV issues and psychological first aid, although there is some concern that these volunteers may not receive sufficient training and supervision to safely and ethically discuss GBV issues with communities.[118]

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[115] https://rohingyaresponse.org/wp-content/uploads/2025/05/GBVSS-Q1-Bulletin-2025.pdf
[116] Key informants.
[117] Govn Key informant.
[118] FGD UNFPA volunteers participants.

UNFPA has also introduced a limited number of WFS' in disasters—especially based on lessons learned from the Rohingya response. And while kit distribution is still essential, more recently, cash modalities have been introduced, including cash for purchasing dignity items and cash for menstrual health and hygiene supplies.[119] For women and girls with disabilities, as noted previously, dignity kits or MHM kits plus cash for assistive devices /aids was piloted in 2024. UNFPA has also provided cash for GBV prevention, including for child marriage protection by making cash conditional on adolescent girls staying in school.[120]

To some extent, UNFPA supports activities aimed at mitigating GBV risks in emergency settings. This includes raising awareness, sensitizing, and advocating to relevant sectors to ensure basic safety measures in temporary shelters like separate toilets for women and girls, sufficient lighting, and privacy and, in 2024, doing some training with other sectors such as food security and WASH. However, working with sectors on risk mitigation was identified by a UNFPA key informant as a critical area for future scale-up. According to an external key informant, "When people go to shelters during floods, everyone stays on the same floor—men/women, use the same bathrooms, there is no privacy, so men and women need separate spaces."[121] GBV prevention programming is also reportedly limited in disaster response.[122]

The most consistent concern raised by key informants was the challenge in disaster response to meet the coverage needs of affected populations. As noted above (see Finding 5), UNFPA meets its own targets in terms of overall SRH and GBV services delivered. However, the ability of the wider disaster response (and UNFPA as the provider of last resort for GBV) to meet the overall coverage for people in need remains severely limited. GBV working groups are absent in some districts, and capacity of service providers remains limited. Many unions have no support mechanisms for survivors.[123] While some efforts are made to expand coverage by coordinating with sister agencies to maximize resources, one UNFPA key informant estimates coverage is about 15% to 20% "at best."[124] Data from UNFPA's humanitarian dashboard for 2023 suggest that UNFPA's target for SRH and GBV services in relation to the total number of people in need was 7 percent that year.[125]

Finding 7. Uptake of GBV services in humanitarian crises in Bangladesh has improved, particularly in the refugee response, but also for disaster-affected populations.

Information from the 9th CPD suggests that in the early days of the **Rohingya response,** UNFPA-supported WFS' responded to the needs of approximately 100,000 women and girls. In 2022, UNFPA-supported WFS' addressed the needs of over 311,000 women and girls,[126] and in 2023, more than 326,000 women and girls accessed GBV prevention and response services through WFS.[127] The GBVIMS 2023 Annual Report further notes improvements in the timeliness of referral and treatment for rape cases reported within the critical 72-hour window in 2023 compared to 2022.

Availability of CMR services in PHCs in Cox's Bazar was reported as 45% in Q2 of 2022.[128] By the end of 2022, 91% of health facilities were offering GBV services, including CMR/IPV or frontline support and referral, with efforts made to strengthen SRH-GBV integration.[129] According to a UNFPA key informant, there has been a significant increase in the willingness to report GBV among the Rohingya population, increasing from 14% of women expressing willingness to report in 2018 to 85% in 2024, according to self-reports and survey respondents.[130] While this is "willingness to report" rather than direct service uptake, it indicates a substantial shift in help-seeking behavior and engagement with reporting mechanisms and likely related support systems.[131]

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[119] UNFPA Key informant.
[120] UNFPA Key informant.
[121] FGD UNFPA volunteers participants.
[122] UNFPA Key Informant.
[123] Cyclone Remal HRP, July 2024.
[124] UNFPA Key Informant.
[125] https://www.unfpa.org/data/dashboard/emergencies
[126] UNFPA 2022 Annual Report
[127] UNFPA 2023 Annual Report
[128] 2022 Q2 GBVSS Bulletin.
[129] GBVIMS 2022 Annual Report
[130] Data cited by UNFPA Key Informant.
[131] UNFPA Key informant.

In **disaster response**, community engagement and mobilization efforts have made communities more "responsive to take quality care from the government facility."[132] There is also evidence that mobile services are reaching excluded communities who are accessing integrated SRH/GBV services for the first time. In one example, during the Northern floods, volunteers and midwives traveled by boat for several hours to reach remote "Char areas" (river islands) in districts like Kurigram, Sirajganj and Gaibandha to conduct mobile SRH health camps and enlist pregnant women for services.[133] This highlights increased access and utilization among previously unreached populations.

To facilitate improved service delivery uptake, UNFPA and IPs undertake regular service delivery assessments that include review of service providers technical capacity.[134] They also facilitate client satisfaction surveys, described by one external key informant as “very good practice”[135], and more passive tools such as complaint/suggestions boxes. A UNFPA interviewee noted that real-time data monitoring of service uptake allows UNFPA to identify areas with low uptake and make programmatic adjustments, such as escalating deployment and adjusting outreach strategies, which implies active efforts to increase utilization in areas where it is lagging.

[132] UNFPA Key Informant
[133] CERF AASRH Response July 24.
[134] UNFPA IP Key Informants.
[135] UNFPA IP Key Informant.

EQ4 (Effectiveness/Coverage)To what extent do UNFPA interventions contribute to the use and dissemination of reliable and disaggregated programme and population data for evidence-based humanitarian responses?

Findings:

8. **UNFPA is facilitating improved collection, use and dissemination of reliable programme and population data in humanitarian response in Bangladesh, although UNFPA could improve its ability to show how its humanitarian support is lifesaving for women and girls (particularly in the area of GBV), and generates important positive impacts for communities more broadly.**

Finding 8. UNFPA is facilitating improved collection, use and dissemination of reliable programme and population data in humanitarian response in Bangladesh, although UNFPA could improve its ability to show how its humanitarian support is lifesaving for women and girls (particularly in the area of GBV), and generates important positive impacts for communities more broadly.

There are many positive examples of how UNFPA facilitates use and dissemination of reliable disaggregated programme and population data in humanitarian response in Bangladesh. In the words of one UNFPA interviewee,

> *In my experience, data, wherever we are managing to collect it [disasters/refugee response], is very helpful in informing many of the strategic, programmatic decisions within and outside of UNFPA.*

Some examples of the many ways in which UNFPA facilitates data collection and uses it to support improved humanitarian response include:

- UNFPA regularly collects data disaggregated by age, sex, location, PwD, type of beneficiaries and services.
- UNFPA contributes to JNA/ISNA and the development of tools like 4W/5W mapping to improve coordination and targeting. Data collected and managed by UNFPA is considered very important in informing programmatic strategic decisions.[136]
- UNFPA, in collaboration with other UN agencies (WFP, FAO, UNICEF) and the Bangladesh Red Crescent Society, has developed a common beneficiary database for households most vulnerable to natural disasters.[137] This database helps assist in strategies for anticipatory action (discussed further below).
- UNFPA has a long-standing partnership with the Bangladesh Bureau of Statistics (BBS.) Support includes work to develop geo-coded digital small-area maps for disaster-prone districts like Khulna, Chandpur, Bagerhat, and Cox's Bazar, specifically to aid in planning humanitarian response efforts at the local level.[138]
- The national GBV cluster information management maintains regular mapping GBV interventions across the country to identify gaps, emergency preparedness and response, preparation and update of GBV referral pathway.
- The SRH WG contributes to information management for UN agencies, NGOs, and local health authorities in Cox's Bazar. Efforts include strengthening surveillance systems for maternal and perinatal mortality data and drafting a standardized Maternal and Child Health (MCH) card to improve information capture and service integration.[139]
- As part of its commitment to AAP, UNFPA engages with communities throughout the project cycle, using tools (some of which have been noted previously) like client satisfaction surveys, FGDs, interviews, courtyard sessions, suggestion boxes, and hotlines. These mechanisms gather feedback from diverse groups, including vulnerable populations. This feedback is routinely used to inform

[136] UN Key Informant.
[137] UNFPA Humanitarian Preparedness Plan 2021.
[138] UNFPA 2022 Annual Report.
[139] SRH Annual Bulletin 2023.

service provision and address programmatic gaps, thereby contributing to evidence-based decision-making driven by community needs and perception.[140] Post-distribution assessments also lead to lessons learned that inform the design of subsequent projects, sometimes resulting in redesigning the response package. For example, feedback from beneficiaries has led to providing cash instead of dignity kits when preferred, adjusting kit items, or delivering healthcare services in specific locations like brothel areas based on community comments. [141]

- UNFPA has been supporting the deployment of the GBVIMS in Cox's Bazar since May 2018. GBVIMS data is explicitly used to inform evidence-based programming, advocacy, and coordination in the response.[142] Currently, there are 14 Data Gathering Organizations and 4 signatories partners are using the GBVIMS system, with quarterly factsheets and annual reports providing a comprehensive summary of GBV issues and trends based on service delivery data as well as other relevant data collected and shared by UNFPA and IPs.
- UNFPA utilizes monitoring systems, including analyzing real-time data on service uptake (such as via Kobo Collect in Cox's Bazar), to identify areas with low uptake, understand bottlenecks, and make quick programmatic adjustments to improve outreach strategies and increase utilization. Data including bi-monthly data collected from IPs is used to publish dashboards for various responses, with data disaggregated by age, sex, location, type of beneficiaries, services, etc. UNFPA also tracks progress against expected timelines and identifies gaps, enabling UNFPA to follow up with partners.[143]

However, there were several areas noted by key informants for improvement. There are ongoing capacity issues amongst government partners in collecting regular humanitarian data, and it was noted by a UNFPA key informant that UNFPA takes on much of that responsibility for its mandate areas. In one example, the use of government data on vulnerable women and households by UNFPA faces challenges in disaggregation by specific vulnerable groups such as trans/third gender populations. Several key informants suggested UNFPA could potentially support the government in improving data collection for these groups.[144]

UNFPA provides technical support to BBS for data generation that supports disaster response in Bangladesh—although the extent of this work is not clear. The only recent UNFPA annual report that references support to BSS is from 2022, which notes that in 2021 UNFPA supported BBS in producing maps for several disaster-prone districts, which can be used in preparing humanitarian response efforts in local communities.[145] A UNFPA key informant stated that UNFPA could and should be more vocal in the IMWG to reflect and reinforce its data capacity and support the government.

In addition, external key informants noted the need to update the MISP calculator, which is still programmed with population data from the previous (2011) census and can now be updated with data from the 2022 census, the final data from which was released in late 2023[146]:

> *A point I'd like to focus on is the MISP calculator, we use to calculate the number of pregnant, lactating mothers of any affected district, but the MISP calculator that we are still using is based on the last census. Maybe they can update it based on the recent census data, so that the accuracy level will be higher.*[147]

The lack of dedicated human resources for M&E for disaster response is another challenge which limits UNFPA capacity on data quality, consistency, timeliness, and disaggregation.[148] Monitoring staff are temporarily appointed by UNFPA and IPs during humanitarian response for 3 to 6 months. Given that the country is prone to natural disaster and vulnerability (ranked 7th for climate risk and exposure to a wide range of hazards on an annual basis, including floods in north, drought in the west, landslides-flood-erosion

[140] Examples cited in project proposal for life skills education for Rohingya adolescents.
[141] UNFPA Key informant.
[142] GBVIMS Fact Sheet 2022.
[143] UNFPA Key informant.
[144] UNFPA IP Key Informants.
[145] UNFPA 2022 Annual Report.
[146] https://tinyurl.com/2fdnz2x3
[147] UNFPA IP Key Informant.
[148] UNFPA Key informant.

in hill tracks, and cyclone in south), several UNFPA key informants noted having a dedicated M&E focal point for disaster response is essential.

As well, the current tracking system for humanitarian response uses basic tools like google sheets to collect data, and a free version of KOBO collect, which is a challenge as this version limits how much data can be collected.

Specifically with anticipatory action, UNFPA has experienced challenges in finalizing a common beneficiary database among agencies involved in anticipatory action, hindering the delivery of comprehensive packages despite recognition of its importance.

> *During COVID 19, we did the joint project with WFP and FAO, and we were distributing multiple rounds of menstrual kits to the women and girls in the slums. So basically, instead of doing one off distribution, we were doing distribution four times a year. But then in that case, it becomes very critical to have the beneficiary data management system so that we don't need to find out who the recipients should be every time we distribute.*[149]

Agencies have internal policies and data sharing agreements that prevent them from contributing to a common list. How to safely and ethically build out a common beneficiary database to facilitate anticipatory action and disaster response is an area the Country Office has consistently kept the regional office informed for support. UNFPA key informants felt it is important for UNFPA at the global level to develop a beneficiary database, accompanied by data protection policies and guidelines that can be utilized across country operations.[150]

Finally, and specifically in relation to GBV data collection, an issue raised by UNFPA staff and by UNFPA IPs in both Cox's Bazar and Dhaka is the lack of common indicators—or data collection efforts generally—that focus on outcomes and/or impact. IPs more often report on activities and numbers reached, rather than behavioral change or other impact indicators, such as women's decreased risk of violence.[151] The absence of baseline or endline evaluations further inhibits the ability of UNFPA and its IPs to measure change.[152] Gathering this data was recognized by UNFPA staff as important to illustrate the life-saving value of GBV interventions—especially in the current context of reduced funding for GBV.

[149] UNFPA Key Informant.
[150] UNFPA Key Informants.
[151] UNFPA IP Key Informant.
[152] UNFPA Key Informant.

EQ5 (Effectiveness) To what extent has UNFPA adequately performed its leadership role on SRHiE and GBViE and Youth, Peace and Security?

Findings:

9. **For the refugee response, UNFPA has overall shown strong leadership in GBV, SRH, and youth coordination, building out capacity and partnership, and addressing challenges effectively as they arise.**
10. **For disaster responses, GBV coordination is widely recognized as effective. SRH coordination has faced more (external) challenges, but it is also functioning effectively. A&Y do not have a separate coordination mechanism; they utilize an integrated approach.**

Finding 9. For the refugee response, UNFPA has overall shown strong leadership in GBV, SRH, and youth coordination, building out capacity and partnership, and addressing challenges effectively as they arise.

In **Cox's Bazar**, UNFPA has taken a clear leadership role in GBV, SRH and youth coordination, with many positive results. In the words of one interviewee, UNFPA is a "very critical part of the overall coordination network" in the refugee response.[153]

GBV Coordination

The GBV Sub-Sector (GBV SS) in Cox's Bazar comprises one international GBV Coordinator, one international Information Management Officer, three national field coordinators (under the GBViE team supporting coordination) and more than 50 standing member organizations including, UN, INGO, NNGO and government agencies operating in the refugee camps and the surrounding affected host community locations. The key strategic objectives of the Sub-Sector include:

1. Ensuring access to quality multi-sector GBV response services for survivors;
2. Building the capacity of GBV service providers and other stakeholders to deliver quality care in line with best practices and minimum standards for humanitarian settings;
3. Enabling active participation of affected communities in GBV awareness raising, response, prevention and risk mitigation;
4. Enhancing GBV risk mitigation across humanitarian sectors and with the government, and
5. Strengthening coordination and planning for the sustainability of the GBV response.[154]

The work of the GBV SS is guided by two-year strategies and rolling action plans, which are developed collectively with coordination partners. The GBV SS includes a designated IM team, which is crucial to ensuring monitoring and reporting on GBV issues and trends across all the service delivery sites supported by GBV coordination partners. The GBVSS collects monthly 5W data from partners using the standardized reporting template as well as GBVIMS data from 18 IPs on service delivery. This regular reporting enables timely analysis of service delivery, supports tracking of progress against key indicators, and helps identify gaps in coverage. The data contributes to GBV SS evidence-based planning, coordination, and advocacy. [155]

With the support of 33 camp focal points, the GBV SS routinely ensures that GBV referral pathways across all Rohingya camps reflect up-to-date service provider contact details.[156] This is critical for timely, safe, and survivor-centered referrals—especially in a context of high staff turnover and constrained funding.[157] In the first quarter of 2025, the GBV SS initiated a comprehensive capacity needs assessment across all levels of partner staff—from senior management to frontline workers. The exercise aimed to identify capacity gaps

[153] UN Key informant.
[154] See https://rohingyaresponse.org/sectors/coxs-bazar/protection/gender-based-violence/#:~:text=The%20Gender%2DBased%20Violence%20Sub,response%2C%20prevention%20and%20risk%20mitigation.&text=5)%20strengthening%20coordination%20and%20planning,sustainability%20of%20the%20GBV%20response.
[155] https://rohingyaresponse.org/wp-content/uploads/2025/05/GBVSS-Q1-Bulletin-2025.pdf
[156] GBV SS Quarterly Bulletin, Q1 2023.
[157] UNFPA Key Informant.

and inform targeted strategies to strengthen GBV programming and improve service delivery. The GBV SS IM team disseminated a GBV service facility mapping tool to assess the number and functionality of available service facilities. These efforts aim to optimize resources and leverage existing funding in light of anticipated funding constraints. [158]

UNFPA was described by one external key informant as filling "a very crucial role" in GBV leadership. Evidence from IP interviewees reinforced this, describing UNFPA's support to coordination partners to address challenges. For example, when a camp authority tried to enter and lock a WFS, the GBV SS took the lead, communicated with the Refugee, Relief and Repatriation Commissioner (RRRC), and organized a coordination meeting with Camp-in-Charges (CICs) to discuss appropriate protocols for this and future such challenges with camp authorities.[159]

The GBV SS works in close collaboration with the Child Protection Sub-Sector (led by UNICEF), and is part of the Protection Sector (led by UNHCR). Some external key informants noted challenges, for example a "siloed approach" among the protection agencies. These challenges appear to reflect and reinforce trust issues between different protection agencies—particularly related to UNFPA's leadership of GBV in a refugee setting where UNHCR often leads.[160]

A contributing factor to these tensions was a temporary staffing gap for the GBV Sub-sector and use of double hatting/surge capacity for a period, reflecting challenges by UNFPA with ensuring the GBV coordinator position was staffed and active.

> *Since I arrived two years ago I have seen four people covering GBV coordination. UNFPA still showed very strong commitment, tried to cover for it but the absence of a GBV person was really affecting.*

Ultimately, UNFPA successfully lobbied for its leadership value and expertise, and resolved the coordinator staffing issue.[161] Key informants noted the protection agencies are improving their cooperation, while also maintaining distinct leadership in their mandate areas. [162] Staffing issues are discussed further EQ 6.

SRH Coordination

In terms of SRH coordination, UNFPA has led the SRH Working Group (SRH WG) since the early stages of the refugee response, which includes over 40 partners, comprising government bodies, NGOs, INGOs, and UN agencies.[163] This leadership is dedicated to delivering SRH services and providing oversight on the quality, accessibility, and coverage of these services.[164] As mentioned previously, the SRH WG, under UNFPA's coordination, launched the GoB Family Planning Strategy for Rohingya Refugees (2022-2025) in collaboration with the Directorate General of Family Planning (DGFP), in 2022.

Further, the SRH WG works to strengthen the skills and knowledge of midwives through mentorship programmes and to standardize the monitoring of SRH interventions, including developing a joint supportive supervision and quality of care monitoring tool.[165] The mentorship program in particular was flagged by an external key informant as an innovative and effective initiative.[166] The SRH WG also coordinates information management for its partners, for example through the Maternal and Perinatal Mortality Surveillance and Response (MPMSR) committee. According to a UNFPA key informant, the SRH WG's efforts have significantly improved the SRH surveillance and reporting system for partners, with information reflected in regular bulletins provided by the SRH WG. A real-time MPMSR dashboard was also developed by the SRH WG to visualize data and inform response planning.[167] As noted previously, the SRH working group collaborates effectively to prevent stock-outs that could arise from long procurement processes.

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[158] https://rohingyaresponse.org/wp-content/uploads/2025/05/GBVSS-Q1-Bulletin-2025.pdf
[159] UNFPA IP Key Informant.
[160] Key informants.
[161] UNFPA and UN Key Informants.
[162] UN Key Informants
[163] Sexual and Reproductive Health Working Group Bulletin: Rohingya Refugee Response, Cox's Bazar. January – December 2023.
[164] UNFPA Key Informant.
[165] UNFPA Key informant.
[166] Donor Key Informant.
[167] Sexual and Reproductive Health Working Group Bulletin: Rohingya Refugee Response, Cox's Bazar. January – December 2023.

A challenge facing the effective coordination of SRHR activities is that the (UNFPA) coordinator of the SRH WG is double hatting, which is a significant responsibility with 40+ coordination partners. The double-hatting came as a result of reduced funding and the need to provide more long-term and nationalized positions for staff. According to a key informant,

> *Double hatting has pros and cons and I think it has more cons. The coordination aspect has the organization's credibility at stake, so need to give it attention. All the deliverables the programme leverages come through the working group. It takes a lot of deliberate effort to make sure nothing falls through the cracks, especially considering the size of the SRH programme.*

Youth Coordination

UNFPA co-leads the Inter-Agency UN Working Group on Adolescent and Young People with NRC under the ISCG. UNFPA recently successfully advocated for the reestablishment of this working group after it had been dormant. The working group now sits directly under the ISCG and is considered a cross-cutting agenda.[168] One UN colleague noted,

> *UNFPA colleagues were very passionate and articulate that we needed a youth working group...but we needed a multi sectoral youth working group, not just under education.*[169]

Cox's Bazar is one of the few refugee responses globally that has a youth working group under the ISCG coordination bodies. Youth issues have gained significant traction in the Joint Response Planning (JRP) process recently, particularly due to the security situation and the recognition of youth as a critical and strategic group.[170] The position of the A&Y coordinator/thematic team lead is currently under a FTA, which supports continuity of dedicated coordination leadership.

With leadership from UNFPA, coordination partners implement tailored programmes like "Girl Shine" for adolescent girls and young women and "Champions of Change" for adolescent boys and young men. These programmes aim to empower A&Y, build life skills, address SRHR and GBV, promote gender equality, and challenge harmful social norms. They are developed using international methodologies and standards, translated, contextualized, and tested within the Rohingya context. Capacity building is provided for coordination partners and project staff on topics relevant to youth programming, including disability-inclusive, gender-responsive, and youth-friendly approaches.

Finding 10. For disaster responses, GBV coordination is widely recognized as effective. SRH coordination has faced more (external) challenges, but it is also functioning effectively. A&Y do not have a separate coordination mechanism; they utilize an integrated approach.

GBV Coordination

Through its leadership of the GBV Cluster, in partnership with the MOWCA, UNFPA has had a "very strong voice" in establishing GBV coordination for **disaster response**.[171] GBV protection issues were not widely considered important in disaster response before the introduction of the GBV Cluster in 2016.[172] The cluster has successfully established that GBV protection issues need to be considered in disasters. As an external key informant reflected, "this means a specific response package considering women's personal identity issues and protection is now familiar to many donors and humanitarian agencies."[173] UNFPA provides technical support to coordination partners in terms of preparing guidelines, setting standards, and undertaking joint planning.[174]

Since 2019 UNFPA as the cluster lead agency, prepares an annual National GBV Cluster work plan, in consultation with members at both national and district levels. Aligned with the HCTT Nexus Strategy 2021-2025, it ensures standardized, inclusive, survivor-centered GBV responses, prioritizing vulnerable

[168] UNFPA Key Informant.
[169] UN Key Informant.
[170] UN Key Informant.
[171] UNFPA IP Key Informant.
[172] TOR for GBV Working Group; 9th CPD Evaluation.
[173] UNFPA IP Key Informant.
[174] National GBV Cluster Work Plan.

groups affected by climate-related disasters.[175] The GBV Cluster also supports integration of GBV into disaster planning and assessments, such as through the Rapid Gender Assessment (RGA) reports, which are produced within 3-4 days of a disaster by the GBV Cluster and the GIHA working group.[176]

In performance terms, cluster partners interviewed for the evaluation were largely positive around UNFPA's leadership, and noted that UNFPA is transparent and helpful in its role.

> *We can communicate with them very easily...just checking that we are in the same way...these are some important areas of the GBV Cluster.*[177]

Operationally, as with other coordination bodies, the UNFPA lead for GBV coordination has been double hatting in the position since 2019, but, unlike the refugee response role, this is reported by UNFPA to not be as significant an issue given the cyclical nature of emergencies. However, there were several areas in which cluster partner interviewees expressed that the GBV Cluster could build out its work, such as capacity building service providers. Cluster partners also noted challenges in terms of ensuring effective coordination at specific disaster-affected locations at sub-national levels.

According to one external key informant, "there is lack of coordination from national level to local level, so we need to focus on that during disaster or after disaster."[178] Moreover, there was a sense from cluster partners that the GBV Cluster could do more to facilitate coordination between government and NGOS. UNFPA as the Cluster lead is scaling up two approaches in this regard - enhancing capacity of women-led organizations at local level in GBV coordination and deploying UNFPA Field Officers in during disaster to support coordination. Relevant Ministries such as social welfare, health, disaster management are being included as members of the national GBV cluster.

SRH Coordination

In the context of national disaster response, UNFPA co-chairs the SRH WG with the Ministry of Health Services, under the Health Cluster. At the local level in impacted districts, UNFPA's field officers and focal points lead coordination with other actors. According to UNFPA key informants, challenges existed with bringing attention to SRH in disasters because the Health Cluster sits under the Infectious Disease Control Department of MOH. Initially, SRH had not been prioritized by Health Cluster leadership because their orientation was towards disease outbreaks. In the past year, UNFPA had to do "a bit of a heavy lifting...to make the SRH Working Group functional" within the Health Cluster, "which is an achievement." [179]

Evidence from evaluation interviewees indicates that UNFPA's efforts have been largely successful. Coordination with other reproductive health partners is described by one external key informant as "fantastic."[180] The SRH working group is described by an external key informant as "very effectively collaborating."[181] District-level SRH working groups were formed in 2024 and include people from the Disaster Management Committee, allowing for discussion among different stakeholders, not limited to health specialists.[182]

Nonetheless, it was noted by an external key informant that coordination with UNICEF in particular—who is another key SRH partner in disaster response-- can be difficult not so much because of any rivalry, but because of each agency's engagement with different government counterparts (DGHS, DGFP and DGNM for UNFPA vs. DGHS for UNICEF). This can lead to poorly harmonized services to beneficiaries if there is insufficient planning before a disaster.[183]

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[175] UNFPA 2022 Annual Report
[176] UNFPA Key Informant.
[177] FGD GBV Coordination Partners.
[178] FGD GBV Coordination Partners.
[179] UNFPA Key Informant.
[180] Govn Key Informant.
[181] UN Key Informant.
[182] UNFPA Key Informant.
[183] UN Key Informant.

Youth Coordination

Unlike in Cox's Bazar, there is no specific A&Y coordination mechanism at the national level for disasters. However, UNFPA has significantly grown its A&Y programming since 2022 with a focus on institutionalization and strengthened partnership with government entities such as the Ministry of Youth and Sports (MoYS), the Ministry of Women and Children Affairs (MoWCA), and the Ministry of Education (MoE). UNFPA has supported MoYS in establishing the National Youth Council at the national level and established youth forums at the sub-national level in disaster prone districts to ensure a youth responsive and community-led coordinated response. [184]

UNFPA had invested in building the capacity of these youth forum members through targeted training on key thematic areas, including climate change adaptation, adolescent sexual and reproductive health and rights (ASRHR), and GBV prevention and response. During the Eastern Floods of 2024, UNFPA effectively mobilized these youth networks in a broader humanitarian response. Youth volunteers played a critical part in supporting the adolescent and youth response, as well as health sector response, particularly at the Civil Surgeon's Office and demonstrated the indispensable role of youth in emergency response.

For disasters, UNFPA integrates its appeals for funding for A&Y into other sector planning, including GBV, SRH, education and WASH.[185] One UNFPA key informant noted that the Youth Compact does not speak to disasters—and would benefit from more inclusion of national disaster components.

[184] UNFPA Key Informant.
[185] UNFPA Humanitarian Preparedness Plan 2022.

EQ6 (Efficiency) To what extent are internal resources, structures, systems, processes, policies and procedures at UNFPA conducive to efficient and timely humanitarian action, at all levels of the organization (global, regional, national)?

Findings:

11. **UNFPA Bangladesh has implemented several procedural improvements and innovations to facilitate humanitarian response, with key support from the UNFPA AP regional office.**
12. **Despite efficiency gains and innovation in humanitarian response, UNFPA Bangladesh still faces challenges with operational agility and partnerships.**
13. **Although well-staffed in comparison to other UNFPA COs, ensuring adequate human resources has been a challenge in both Cox's Bazar and in UNFPA's disaster response.**

Finding 11. UNFPA Bangladesh has implemented several procedural improvements and innovations to facilitate humanitarian response, with key support from the UNFPA AP regional office.

A significant achievement of the Bangladesh CO was the finalization in 2023 of country-level SOPs that guide the CO in its initial response to natural disasters affecting the country triggering a L1 and L2 in-country led response, managed directly by the CO. These SOPs outline key steps, budget, emergency funding processes, timelines, roles, and responsibilities for both preparedness and response. The SOPs were tested and used for four consecutive responses after their finalization. According to a UNFPA key informant, their implementation has reduced response time significantly, from nearly three months after a disaster to three days, which IP key informants also noted. The value of the country-level SOPs was repeatedly confirmed by UNFPA staff, not least because they are contextualized to the dynamics and complexities of Bangladesh.

Complementing the SOPs, the CO produces annual contingency plans for humanitarian response. In addition, in 2024, UNFPA Bangladesh finalized an Anticipatory Action protocol that draws from global guidance (which does not appear to have yet been published).[186] The CO has also adapted regional guidance on AAP to Bangladesh context to make it more operational.

Another example of a key efficiency measure was the introduction of decentralized procurement procedures in 2021.[187] Via these, UNFPA has decentralized warehouses to IPs located in disaster-prone areas. This is a lower-cost option compared to central commercial warehouses and allows for quick mobilization of items to distribution centers close to communities. IPs also handle local procurement of humanitarian items, avoiding international procurement delays and using locally available, lower-cost items wherever possible.

The UNFPA CO has participated in and/or introduced a number of other innovations, such as those mentioned previously: AA, and the use of cash and voucher assistance leveraging blockchain technology for security.[188] Several UNFPA key informants noted how useful the regional office has been in facilitating learning and providing support to some of these initiatives. UNFPA key informants also variously noted that the regional office has also supported in areas including A&Y, AAP, integrating disability inclusion, and pre-positioning of supplies.

> *We are at the front line in terms of implementation of the anticipatory action and cash voucher assistance. And we share information with APRO very closely, and they also provide advice and support in these areas. So we really have very good, close collaboration with the regional office.*[189]

[186] UNFPA Bangladesh CO Anticipatory Action Protocol, Nov 2024.
[187] UNFPA 2021 Humanitarian Preparedness Plan.
[188] Blockchain supports paperless vouchers, which enables a one-stop shop for beneficiaries to receive aid from multiple agencies, reducing inefficiencies, travel burdens, and risks such as gender-based violence. For example, women and girls in Dhaka's urban slums can redeem sanitary pads and nutritious food at local vendors using the BB platform.
[189] UNFPA Key Informant.

Evaluation key informants were less positive regarding support from HRD, noting that the relationship was less clear. Several acknowledged that HRD's readiness to deploy the emergency fund mechanism has been useful, for example a rapid approval and transfer of bridging funds to cover gaps in Cox's Bazar following the 2025 US funding cuts. Nonetheless, a UNFPA key informant noted that communication flow between HRD, the regional office, and the country office is "not still entirely clear", citing the example of communication disconnects, where HRD requests information already provided by the CO to the regional office.

Further, the link between HQ-level discussions (e.g., on AA) and country-level operations is felt to be not always effective, with one UNFPA key informant noting gaps in structured internal communication and coordination to help country offices position themselves on global issues.[190] HRD collaboration with country offices was described by the key informant as focusing more on supporting reporting requirements for donor-driven frameworks (like CERF) rather than establishing UNFPA's own clear framework for humanitarian response delivery and efficiency thresholds.[191]

Finding 12. Despite efficiency gains and innovation in humanitarian response, UNFPA Bangladesh still faces challenges with operational agility and partnerships.

While the evaluation evidence indicates that the contextualized SOPs are a significant benefit to the CO, challenges remain with timely resource mobilization, particularly the transfer of cash to IPs for rapid response to disasters. Delays can be significant, sometimes 20-25 days or even a month for emergency funding according to external key informants.[192] This is especially challenging with short-term projects and immediate life-saving needs.

> *What is the ongoing challenge, because it's related with the programme implementation, is the fund disbursing … sometimes consumes two or three months to pay under disbursing. So during this period, we need to continue our work from our fund, our own organizational fund.*[193]

UNFPA staff corroborated these challenges, with recognition of the need to establish a mechanism for continuous availability of a budget to draw on at very short notice due to the frequency of disaster responses in Bangladesh. A comparison was made by a UNFPA key informant to UNICEF, which the key informant noted has core funding available in a separate pool for humanitarian purposes:

> *If [UNFPA] wants to stay relevant during disasters, then we need to have our own sort of substantive funds that we can quickly channelize. UNICEF has it, but we don't have it, and our mandate is equally important.*[194]

In addition to availability of funds/ budget, UNFPA processes of work planning, fund disbursement to IPs and other related operational processes are not conducive for an agile humanitarian response. The humanitarian unit has limited access to humanitarian IP workplans, and subsequent monitoring and implementation, and it reportedly leads to challenges in maintaining standards.[195]

IPs expressed a desire for more reciprocal accountability and engagement in both Cox's Bazar and at the national level, such as IPs having a stronger voice in programme design and adaptation. Interviewees from IPs noted that they would like to meet more systematically as a group with UNFPA thematic leads, expressing the need for project co-planning (between UNFPA and IPs) to ensure activities, budget, etc. are relevant to the context.

> *In most of the cases, we are not involved in the design interface. So when the project is designed, and then they are communicating with us the project, that is what we have, and we have to respond accordingly, then it becomes challenging for us, because sometimes the ground*

[190] UNFPA Key Informant.
[191] UNFPA Key informant.
[192] UNFPA IP Key Informant
[193] UNFPA IP Key Informant.
[194] UNFPA Key Informant.
[195] UNFPA Key Informant.

> *reality is different. We are on the ground as an implementing partner and working very closely with the community, we know the ground reality and in terms of staffing, budgeting, how much it should be--but that is not being checked with us. Maybe there are reasons behind that, maybe time limitations and other things, but my experience when it is coming in a way top down, and we are bound to work within that, because they don't have any ways to change anything as required as according to the ground reality, then it becomes a challenge to accommodate within that and complete the response.*[196]

IPs also flagged issues with implementing the new Quantum technology starting in 2024. IPs reported they did not receive sufficient capacity development or formal training on the “sudden shift” to the Quantum system from UNFPA. One IP mentioned, "we didn't get any capacity from them”, while another IP indicated issues are "still not resolved” despite on-going trouble shooting with UNFPA.[197] An external key informant surmised that that these issues were linked to one (“unusual, for UNFPA”) underspend significant enough to require the donor to recoup money.[198]

Finding 13. Although well-staffed in comparison to other UNFPA COs, ensuring adequate human resources has been a challenge in both Cox’s Bazar and in UNFPA’s disaster response.

The UNFPA humanitarian team in Dhaka, since 2017, has centered around a dedicated humanitarian coordination specialist based in the CO to oversee UNFPA’s response to disasters, supported by a disaster response humanitarian team comprised of staff from core programme units. This core team is responsible for central coordination of humanitarian disaster preparedness and response, working alongside a broader team comprising thematic focal points from SRHR, A&Y, and Gender units, as well as staff from Operations, Comms and M&E. Each thematic team has a dedicated person for emergency work, who also handles development tasks. PPR is specifically responsible for managing beneficiary databases.[199]

All unit team members, even under the development program, have received training in humanitarian protocols with the strategic goal—according to a UNFPA key informant--being that every UNFPA Bangladesh staff member has the ability to respond to an emergency. However, one key capacity gap identified by evaluation key informants was the need for a dedicated M&E position for disaster response, as noted above. Moreover, several UNFPA key informants felt the scope and frequency of disasters in Bangladesh require a more substantial team of humanitarian-dedicated staff than has existed to date. One UNFPA key informant expressed the view that it is "time to make a full-face humanitarian team for the Bangladesh country office," a team that would work "for the whole year all together, not on a piecemeal basis." However, this perspective is not shared across all UNFPA staff, with one UNFPA key informant noting that if additional capacity is needed for disaster response, then more programme staff should be mobilized.

For the Cox’s Bazar refugee response, UNFPA operates a standalone humanitarian sub-office in Cox’s Bazar staffed by one HoSO (role is equivalent to a senior emergency coordinator), one humanitarian coordinator, supported by humanitarian GBV, SRH and A&Y coordination, programme and operations staff. While this sub-office is currently well-staffed and described as meeting needs, in the past there have been leadership vacuums and severe staffing reductions in key areas like GBV coordination, impacting agency presence, strength and advocacy capacity.[200] One reason for this, according to several UNFPA key informants, was that staff were previously on temporary appointments or service contracts.

A human resources realignment took place around mid-2023, of which the primary goal was to transition a large number of Cox’s Bazar staff to fixed-term contracts (FTA) instead of temporary appointments or service contracts.[201] This was intended to provide greater stability and better contractual conditions for staff members, motivating them to stay longer. The realignment also aimed to empower senior national staff by upgrading positions (e.g., to NOCs, NOBs) so that the office could be self-sustained even if resources for

[196] UNFPA IP Key Informant.
[197] UNFPA IP Key Informants.
[198] Donor Key Informant.
[199] See UNFP Bangladesh SOPs for Humanitarian Operations (2023) and UNFPA Bangladesh Contingency Plan 2024 for specific details of humanitarian response team arrangement.
[200] UNFPA and UN Key Informants.
[201] UNFPA Key Informant.

international positions were limited. While it reduced the number of international staff, it increased the number of national staff in senior roles.[202]

UNFPA Cox's Bazar managed to complete a "remarkable" 40 recruitments in one year as part of this realignment.[203] Out of almost 53 people in the Cox's Bazar team, only three or four now have service contracts, with everyone else holding a fixed-term contract. Notably, however, these FT positions are still not paid through core resources; they remain reliant on donor funding.[204]

EQ7 (Coherence) To what extent are UNFPA humanitarian interventions internally coherent and complementary to that of other humanitarian actors, thus reducing gaps, avoiding duplications and creating synergies?

Findings:

14. **UNFPA has mainstreamed integration of GBV, SRH and youth services as a standard approach in both refugee response and disasters to build synergies and maximize resources.**
15. **UNFPA harmonizes humanitarian response activities with sister agencies via a number of useful channels, although disaster response resolution on the common beneficiary database has impacted coordination on service delivery for AA.**

Finding 14. UNFPA has mainstreamed integration of GBV, SRH and youth services as a standard approach in both refugee response and disasters to build synergies and maximize resources.

UNFPA in Bangladesh has actively pursued the co-location and integration of its mandate areas of GBV, SRH and youth in its programming approaches. Policies (e.g. 10th CPD, SOPs, AA protocol), plans (e.g. UNFPA's internal annual contingency plans and HRPs) and projects support this integration.

Examples of integration in the refugee response include:

- GBV case workers are placed in SRH facilities supported by UNFPA.
- SRH midwives are placed in WFS. These midwives are trained and mentored by the SRH unit and funded by them. SRH services are also available in youth centers.
- All UNFPA's centers and facilities generally provide a service for referral to its other programmes.
- Thematic components of GBV and SRH are integrated into life skills education programmes for adolescents and youth, with sessions sometimes taking place in WFS.
- The GBV Sub-Sector works with the SRH Working Group to strengthen SRH-GBV integration in both health facilities and safe spaces through joint advocacy and capacity building

Examples from disaster response include:

- Mobile SRH Health Camps used during disasters to bring services directly to communities, particularly in hard-to-reach areas. These can provide referrals for GBV response services and PFA. Adolescent health services are included in SRH services, and adolescents are welcome at union-level facilities for counselling on health issues and preventing child marriage.
- Union-level health facilities are supported to provide life-saving SRH and health sector response to GBV services and referrals through midwives.
- The A&Y and GBV programmes have supported phone counselling services for youth at the national level, including those affected by disasters.
- Midwives are placed in centers supported by other agencies, demonstrating integration beyond UNFPA's direct facilities.

UNFPA documentation regularly emphasizes the benefits of this integration, in terms of ensuring needs of women and girls are met more comprehensively; programmes are mutually supportive; and entry points for women and girls to access services are amplified. Equally, UNFPA key informants expressed the benefits of integration in terms of maximizing resources and expanding support to affected populations. In one

[202] UNFPA Key Informant.
[203] UNFPA Key Informant.
[204] UNFPA Key Informant.

empirical example, data shows the number of adolescents accessing FP from the WFS is growing. The SRH survey 2024 concluded that adolescent pregnancies are falling: between 2018 and 2024 adolescent pregnancies have fallen from over 18% to 7%.[205]

Finding 15. UNFPA harmonizes humanitarian response activities with sister agencies via a number of useful channels, although disaster response resolution on the common beneficiary database has impacted coordination on service delivery for AA.

UNFPA's 10th CPD explicitly emphasizes the importance of partnerships at all levels, including through joint programming with other United Nations entities. Examples[206] of ways in which UNFPA coordinates with other agencies to create synergies and reduce duplication include:

- Aside from coordination responsibilities described under EQ 5, UNFPA also participates in other relevant clusters and working groups, including the Health Cluster, WASH Cluster, Education Cluster, Child Protection Cluster, Needs Assessment Working Group, Information Management Working Group, Inter-Cluster Coordination Group, Humanitarian Advisory Group, Inter-Sectoral Coordination Group, and the Cash Working Group.
- UNFPA collaborates with other UN agencies in conducting joint needs assessments, such as through the NAWG. UNFPA also participates in coordinating data collection modalities with mechanisms like the GBV cluster and GiHA led by UN Women. UNFPA engages in joint information management initiatives, such as contributing to the 5W matrix, and supporting the collection, analysis, and sharing of data across sectors to inform decision-making.
- UNFPA is involved in multi-sectoral consultative processes to develop HRPs. This includes mainstreaming SRH, A&Y, and gender issues within these plans.
- UNFPA also contributes to the development of inter-agency strategies and frameworks, such as the HCTT Nexus Strategy for climate-related disasters, and the National Adaptation Plan for Health.
- Since 2019, UNFPA has been actively involved in AA frameworks as part of a coalition that includes WFP, FAO, UNICEF, the Bangladesh Red Crescent Society, and IFRC, under the leadership of the Resident Coordinator supported by OCHA. CERF funding for AA is allocated to multiple agencies, including UNFPA, WFP, FAO, and UNICEF.
- UNFPA coordinates its sectoral CVA efforts (e.g., cash for dignity items, MHM) with other humanitarian actors, including UN agencies like WFP, who provide multi-purpose cash. This coordination, often facilitated through the Cash Working Group, aims to ensure that different types of assistance are complementary and meet the diverse needs of affected populations.
- UNFPA participates in joint monitoring visits, lessons learned workshops, and After-Action Reviews to assess the effectiveness of interventions and improve future responses collectively.

There was little information from the key informant interviews about specific joint programmes beyond anticipatory action; this may be a gap in the research. External key informants shared that in disaster response, there have been instances of agencies having common distribution points for different types of non-food items (for example UNFPA's protection items, UNICEF's WASH items, FAO's cattle feed), which happened “organically” on an ad-hoc basis as part of individual acute disaster responses (as opposed to as part of a more systematic strategy or agreement).[207]

However (as discussed under EQ 4 above), the challenges in finalizing a common beneficiary database that can be shared across agencies (within the bounds of appropriate ethical and security safeguards) has been identified by as a barrier to providing a comprehensive and non-duplicative package of support to vulnerable families (e.g., one family receiving SRHR from UNFPA, cash from WFP, and livestock support from FAO).[208] This is partly due to data sharing agreements and different organizational mandates.[209] For example, WFP’s data collection is designed for household-level support, whereas UNFPA's needs are targeted at individual vulnerable women and girls. UNFPA had no reason to agree to join the common beneficiary database that cannot be used for its own targeted group.

[205] https://bangladesh.unfpa.org/sites/default/files/pub-pdf/2024-10/SRH%20survey%20Broucher%20%20%284%29.pdf
[206] Drawn from internal and external reporting/documentation and/or cited by evaluation interviewees.
[207] UN Key Informant.
[208] UN Key Informant.
[209] UNFPA Key Informant.

UNFPA has received support from the regional office to address challenges around building a common beneficiary database, but it was noted by a UNFPA key informant that (a) CO Bangladesh has been communicating to HQ on the need to create a corporate beneficiary database (noted above), and (b) HRD has not necessarily been proactive in this regard. The Bangladesh AA Framework for flood response, drafted in April 2025, notes that WFP is currently finalizing data sharing agreements with other agencies.[210]

[210] OCHA Anticipatory Action Framework, Bangladesh Monsoon Floods—2025 Version

EQ8 (Connectedness) To what extent is humanitarian action at UNFPA linked to preparedness and longer term development processes and programmes, across the humanitarian-development-peace nexus?

Findings:

16. **UNFPA promotes several humanitarian preparedness and response interventions in Bangladesh that support, and plan for, longer-term developmental and resilience-related goals.**
17. **While UNFPA's humanitarian interventions often include capacity development and ownership at national and local levels, short-term and limited funding affects success in this area.**

Finding 16. UNFPA promotes several humanitarian preparedness and response interventions in Bangladesh that support, and plan for, longer-term developmental and resilience-related goals.

As noted under EQ1, the current UNFPA Bangladesh country programme explicitly and repeatedly references the nexus between humanitarian and development contexts, noting "UNFPA will leverage its comparative advantages across the humanitarian-development continuum." This important strategic framing creates space within UNFPA's mandate to implement activities that bridge these areas.

UNFPA SOPs for humanitarian response outline steps for both preparedness and response, including roles and timelines, contributing to overall readiness. In addition, the 2024 UNFPA internal contingency plan for disaster response also references early recovery. UNFPA has also developed CO guidance on anticipatory action. The purpose of this protocol is to guide the Country Office in maintaining a state of readiness to activate and implement its integrated anticipatory action programmatic activities, emphasizing that action early "can help protect hard-won development gains." [211]

As noted in EQ1, UNFPA participates in the interagency Anticipatory Action Technical Working Group under the MoDMR, linked to the HCTT. This group guides and directs effective AA interventions at local levels. An external key informant noted that UNFPA is very active in this group in terms of advocating for attention to its mandate areas.[212] However, one area for improvement that has been previously identified (EQ 6) is in addressing bottlenecks in funding to IPs for AA, so that IPs are not forced to 'pre-finance' initial costs while funds are being transferred. One UNFPA key informant recommended that UNFPA develop a specific global or regional-level fund for this purpose (and/or avail of money within HQ core resources for this purpose from existing instruments (the ER, the HFT and the Emergency Response Reserve) that are intended for this, or similar, purpose.

> *We don't have any flexible policies and procedures supporting this system, like we had to distribute cash to the beneficiaries. But implementing partners supported us. They withdrew their own money to distribute cash because UNFPA was not able to transfer this cash to the IP at that quick time. So that financial procedure should be in place to support these kind of activities.*[213]

Programmatically, UNFPA also implements initiatives that are integrated with the HDP nexus. Examples include provision of conditional cash support for adolescent girls to stay in school after disasters, specifically aimed at preventing child marriage, a harmful norm often exacerbated by crises, contributing to longer-term resilience against such social vulnerabilities. In addition, UNFPA support to MHPSS in emergency settings also contributes to the resilience and well-being of affected populations. UNFPA has also drawn from its emergency work—such as support to the national hotline in emergency response—to build out the hotline response in development, illustrating how emergencies can inform and improve development.

Another interesting area where there may be challenges and opportunities around nexus and resilience work is coordination, particularly in relation to the GBV Cluster in Dhaka. According to a UNFPA key

[211] UNFPA Bangladesh CO Anticipatory Action Protocol, Nov 2024.
[212] UN Key Informant.
[213] UNFPA Key Informant.

informant, the cluster is activated for emergency disaster response, despite its stated commitment to support GBV response before, during and after emergencies.[214] GBV coordination for disaster preparedness and response could be a very natural place to link development and humanitarian actors, including in terms of building out ongoing sub-national GBV coordination mechanisms.

Finally, in the Rohingya response, the government's primary focus on repatriation undercuts the feasibility of implementing any longer-term resilience or livelihood programmes for refugees.[215] Nevertheless, UNFPA is considering approaches for transitioning towards more area-based responses in this response, recognizing the overlap between humanitarian and development needs given that the Rohingya have been in Bangladesh for eight years. UNFPA has engaged in discussions with and received funding from International Financial Institutions such as the World Bank and Asian Development Bank, recognizing the potential for development funding to support resilience activities for both host and refugee populations. As noted previously in EQ3, this approach holds promise to address some of the humanitarian funding shortfalls UNFPA is facing in Cox's Bazar, and is also in line with the emerging global UNFPA resource mobilization strategy since the withdrawal of the US Government from the international ODA arena.

Finding 17. While UNFPA's humanitarian interventions often include capacity development and ownership at national and local levels, short-term and limited funding affects success in this area.

Strengthening the capacity of government institutions and local implementing partners is a key component for sustainability and longer-term impact that is integrated in many of UNFPA's interventions. UNFPA's work aims to "converge with the government's plans and policies."[216] A key example of this is the integration of the MISP into the government operational plan, which covers both development and disasters. Further, as noted in EQ4, UNFPA has engaged in efforts to build the capacity of government offices to collect humanitarian data.[217] According to one UNFPA key informant, for disaster response "Everything is done by the government, through the government."[218] For example, UNFPA trains midwives in collaboration with the government and deploys them to government facilities, where they are monitored by government personnel and utilize existing government infrastructure, making the humanitarian response "just integrated part of the government system"

Government partners expressed their appreciation of UNFPA investments to build capacity of relevant government authorities on GBV and SRH priorities, supporting the strengthening of health systems within affected locations through a localized approach, including building the capacity of the local government and NGO partners.[219] UNFPA explicitly mentions granting a significant percentage (83% in the case of one project) of its allocation to national SRH partners and supporting their capacity development.[220] UNFPA's advocacy with national and local government authorities (like the Directorate General of Nursing and Midwifery) for the continued deployment or reshuffling of midwives after a disaster response is another example of a sustainability approach in Bangladesh.[221]

For GBV, UNFPA dedicates "significant time and resources… to building the capacity of its local IPs."[222] According to IPs, this support has enabled some smaller organizations to grow and become capable of running programs independently.[223] Key informants emphasized that in both refugee and disaster response, working purposefully with women-led and grassroots organizations is a strategy for supporting sustainability.[224] UNFPA has on-going partnerships and MOUs with its IPs, and prioritizes multi-year funding as is possible, particularly in Cox's Bazar where the majority of UNFPA's IPs are local.[225] UNFPA key informants noted that developing referral pathways and engaging relevant government departments (like the Department of Women Affairs) in the process is a strategy to sustain these mechanisms. Training of

[214] Bangladesh GBV Cluster TOR, 2023.
[215] UN and UNFPA Key Informants.
[216] UNFPA Key Informant.
[217] UNFPA 2022 Annual Report.
[218] UNFPA Key Informant.
[219] Govn Key Informants.
[220] CERF UF Request OI88_23-UF-FPA-047_Bangladesh_Project
[221] UNFPA Key Informant.
[222] UNFPA Key Informant.
[223] UNFPA IPs Key Informants.
[224] UNFPA Key Informant.
[225] UNFPA Key Informant.

youth volunteers to manage youth centers in the Rohingya camps is another example of building out localization efforts.

Particularly in disasters, however, the capacity building of national and local systems and partners is challenged by short-term and limited funding. UNFPA supports community PSS volunteers and encourages community-based approaches. However, when asked about the sustainability of programming initiated for disaster response, a UNFPA key informant noted:

> *Volunteers came from the impacted community, so they are based in that community. So we capacitated them on safe referral--this is a sustainable thing in terms of building the communities. But the counselor who deployed to the government facility, I would say that is not fully sustainable, because whenever any disaster ends they lose funding. But there is some progress, like in our eastern flood, the understanding about the importance of MISP was not there among the government, but through our humanitarian response, at least now, they understand the importance.*[226]

UNFPA key informants noted that development work with IPs helps to support capacity in disaster response, but the scope is still limited. In Cox's Bazar, the potential for new funding from IFIs is a promising approach to supporting greater sustainability of systems even in the protracted refugee response.

[226] UNFPA Key Informant.

Conclusions

1. UNFPA in Bangladesh is committed to investing in climate adaptation and working across the nexus, and is spearheading many important initiatives that facilitate preparedness, early disaster response, resilient early recovery, and, in Cox's Bazar, area-based responses that include host communities. The current CPD underscores this commitment, as does UNFPA's innovative programming such as cash and voucher assistance, anticipatory action and decentralized procurement. However, there is no specific articulation in the CPD or in specific country programme guidance on what the nexus entails for the CO.

   Links to Findings 1, 8,11,13,16

2. UNFPA is widely recognized as a key UN partner in the Rohingya refugee response and in response to sudden-onset natural disasters in Bangladesh. Its facilitation of SRH, GBV, and A&Y coordination and programming has positioned UNFPA as a leader in these sectors. However, funding for these sectors remains consistently lower than other humanitarian sectors. This presents significant challenges to coverage of needs, particularly in disaster response. UNFPA has used and continues to diversify funding mechanisms to expand coverage, such as through IFI funding in Cox's Bazar.

   Links to Findings 2,6,7,9,10

3. UNFPA plays a crucial role in data collection in humanitarian response, from assessments to targeted surveys to information management to programme monitoring, utilizing data to support the wider humanitarian community and to improve UNFPA's own programmatic response. However, several specific areas emerged for improvement in data collection and management for disaster preparedness and response. This includes pre-disaster consultations with affected populations, developing a common beneficiary database, and updating the MISP calculator. Data collection could also focus more strategically on capturing the impact of services, to better illustrate the life-saving nature of UNFPA-supported interventions, particularly related to GBV.

   Links to Findings 3,8,15

4. UNFPA support has led to significant increases in utilization of a range of SRH, GBV and A&Y services in Cox's Bazar and to a lesser, but still important, extent in sudden-onset disasters (where the primary responsibility for service delivery lies with the GoB) over the evaluation period. UNFPA has supported improvement in the quality of these services over time to better address the needs of specific populations, such as PWD and third gender populations. Moreover, UNFPA has sought to maximize efficiency in delivery of services through integrated approaches. However, despite UNFPA's strong relationship with the Government of Bangladesh and their endorsement of the criticality of UNFPA mandated areas in humanitarian response, ensuring SRH, GBV and A&Y services in humanitarian response presents ongoing and future challenges, particularly in relation to accelerating funding shortfalls.

   Links to Findings 4,5,6, 7,14,17

5. UNFPA has launched several procedural improvements and innovations at the CO level to facilitate humanitarian response, including developing its own SOPs for the CO's initial response to natural disaster triggering L1 and L2 in country-led response and drafting annual UNFPA-specific contingency plans for disaster response. Nevertheless, there are still some challenges with operational agility and accountability to IPs, particularly in terms of ensuring rapid disbursement of funds to partners in the early stages of disaster response.

   Links to Finding 11,12,16

Suggestions for Action

Key suggested actions at country level

A. In the next CPD, to align with the global humanitarian strategy and to effectively operationalize UNFPA's humanitarian mandate, a dedicated output on humanitarian action is critical. UNFPA Bangladesh should also provide explicit reference to the core elements of working at the nexus in the CPD.

Linking to conclusions 1,4

B. UNFPA should continue its innovative work to explore different funding streams for emergencies, including through anticipatory action and engagement with IFIs. As part of this, UNFPA must be able to illustrate clearly the life-saving nature of its work (see recommendation C). UNFPA Bangladesh should document successes for wider agency learning.

Linking to conclusion 2

C. UNFPA Bangladesh should consider ways in which it can improve several key areas of data collection and monitoring in emergencies, such as designing pre-disaster needs assessments directly with affected populations and developing more standardized approaches to illustrating the life-saving impact of GBV interventions. UNFPA Bangladesh should also update the MISP calculator for Bangladesh.

Linking to conclusion 3

D. UNFPA Bangladesh should accelerate its efforts to promote government ownership and leadership in SRH, GBV and A&Y, particularly in terms of coordination and supplies management.

Linking to conclusion 4

Key suggested actions at global level

E. UNFPA HRD should support learning from CO's globally (including Bangladesh) to develop guidance on working at the nexus, not least as an important corporate strategy for accessing a greater variety of funds in humanitarian response, but also to elevate UNFPA's position as a nexus agency. This could also include finalizing specific guidance on Anticipatory Action.

Linking to conclusion 1

F. UNFPA should establish a UNFPA-specific corporate beneficiary database with associated guidance on uptake for COs.

Linking to conclusion 3

G. UNFPA HRD should support the development of better monitoring systems for emergencies with a clear set of indicators. This monitoring should include strategies for collecting and sharing data on the life-saving impact of GBV programming (alongside SRH and A&Y programming).

Linking to conclusion 3

H. UNFPA should streamline its financial and administrative procedures to reduce delays for implementing partners in receiving funding, and develop strategies for more consistent engagement with IPs in project planning and financial management, including minimizing or eliminating pre-financing of activities by local partners.

Linking to conclusion 5

Annexes

Annex I: List of Key informants

Note: Many of these key informants participated in group interviews.

Agency	Agency type	Location	Role
UNFPA	UN Agency	Bagerhat	Field Officer
GreenHill	NGO	Bandarban	Project Director
UNFPA	UN Agency	Bandarban	Field Officer
UNFPA	UN Agency	Barguna	Field Officer
Refugee Relief and Repatriation Commission	Government	Cox's Bazar	Refugee Relief and Repatriation Commissioner
DDFP office	Government	Cox's Bazar	DDFP
Intersector Coordination Group	Coordination Body	Cox's Bazar	Coordinator
WHO	UN Agency	Cox's Bazar	Health Sector Coordinator
UNFPA	UN Agency	Cox's Bazar	SRH Working Group Coordinator
UNFPA	UN Agency	Cox's Bazar	YWG Working Group Coordinator
UNFPA	UN Agency	Cox's Bazar	GBVSS Coordinator
Friendship	NGO	Cox's Bazar	Deputy Director - Health
Mukti	NGO	Cox's Bazar	Program Manager
Plan International	NGO	Cox's Bazar	Program Manager
Prottyashi	NGO	Cox's Bazar	Program Manager
Mukti	NGO	Cox's Bazar	Program manager
RTMI	NGO	Cox's Bazar	Sr. Project Manager
IRC	INGO	Cox's Bazar	Women Protection & Empowerment (WPE) Coordinator
PHD	NGO	Cox's Bazar	Senior Deputy Director
IPAS	INGO	Cox's Bazar	Project Manager
GUK	NGO	Cox's Bazar	Program Coordinator
AAB	NGO	Cox's Bazar	Project Manager
BRAC	NGO	Cox's Bazar	Project Manager
World Bank	IFI/Donor	Cox's Bazar	Senior Social Development Specialist
UNFPA	CO	Dhaka	M&E Specialist
UNFPA	CO	Dhaka	Humanitarian Coordinator
UNFPA	CO	Dhaka	Humanitarian Specialist
KOICA	Donor	Dhaka	Senior Development Specialist
Swiss Agency for Development and Cooperation (SDC)	Donor	Dhaka	Programme Officer – Humanitarian Aid and Nexus

UNFPA	UN Agency	Dhaka	Humanitarian Specialist
UNFPA	UN Agency	Dhaka	GBV Cluster Coordinator
UNFPA	UN Agency	Dhaka	Humanitarian Reporting Officer
UNFPA	UN Agency	Dhaka	Information Management Officer
UNFPA	UN Agency	Dhaka	Programme Associate- Humanitarian Response
UNFPA	UN Agency	Dhaka	Programme Specialist - Maternal Health
UNFPA	UN Agency	Dhaka	GBV in Emergency Program Officer
UNFPA	UN Agency	Dhaka	Programme Officer- Humanitarian
UNFPA	UN Agency	Dhaka	Chief of Health
UNFPA	UN Agency	Dhaka	SRH Specialist
UNFPA	UN Agency	Dhaka	Program Assistant
UNFPA	UN Agency	Dhaka	Unit chief, Gender
UNFPA	UN Agency	Dhaka	Program Specialist, A&Y
UNFPA	UN Agency	Dhaka	Program Analyst
UNFPA	UN Agency	Dhaka	M&E Specialist
UNFPA	UN Agency	Dhaka	National Programme Officer
UNFPA	UN Agency	Dhaka	M&E Officer
UNFPA	UN Agency	Dhaka	Programme Officer - Media and Communication
UNFPA	UN Agency	Dhaka	International Operations Manager
UNFPA	UN Agency	Dhaka	Finance Officer
ActionAid Bangladesh	GBV Cluster	Dhaka	Deputy Manager – Women's Rights and Gender Equity
Concern Worldwide	GBV Cluster	Dhaka	Gender Coordinator
World Vision	GBV Cluster	Dhaka	National Coordinator
Humanity and Inclusion (HI)	GBV Cluster	Dhaka	Protection Technical Specialist
Manusher Jonne Foundation (MJF)	GBV Cluster	Dhaka	Programme Manager
Concerned Women for Family Development (CWFD)	GBV Cluster	Dhaka	Coordinator-Helpdesk of CWFD
Concerned Women for Family Development (CWFD)	GBV Cluster	Dhaka	Deputy Executive Director
Naripokkho	GBV Cluster	Dhaka	Members of Naripokkho
CIPRB	NGO	Dhaka	Project Manager
ActionAid Bangladesh	NGO	Dhaka	Head of Humanitarian Programme
Concerned Women for Family Development (CWFD	NGO	Dhaka	Programme Manager- Humanitarian
Australian High Commission	Donor	Dhaka	Deputy Humanitarian Advisor

Australian High Commission	Donor	Dhaka	Deputy High Commissioner
DGHS	Government	Dhaka	Deputy Program Manager- EOC
DGHS	Government	Dhaka	Program manager DGFP (Adolescent health)
DGHS	Government	Dhaka	Assistant Director, Midwifery
MoDMR	Government	Dhaka	Additional Secretary (MoDMR) and Director, Cyclone Preparedness Program (CPP)
MoWCA	Government	Dhaka	Joint Secretary, MoWCA and Co-Chair of GBV Cluster
WFP	UN Agency	Dhaka	Anticipatory Action Specialist
Unicef	UN Agency	Dhaka	National Wash cluster coordinator
FAO	UN Agency	Dhaka	National Programme Specialist, Emergency and Resilience
BDRCS	NGO	Dhaka	Coordinator, National AA technical working group
Needs Assessment Group	Working group	Dhaka	Needs Assessment Working Group Coordinator
UNRCO	UN Agency	Dhaka	RC
Prerona	NGO	Dhaka	ED
Bandhu	NGO	Dhaka	ED
UNFPA	UN Agency	Gaibandha	Field Officer
Lamb Hospital	NGO	Gaibandha	Project Manager
Gana Unnayan Kendra	NGO	Gaibandha	Humanitarian coordinator
UNFPA	UN Agency	Jamalpur	Field Officer
PHD	NGO	Noakhali	Senior Deputy Director, PHD
UNFPA	UN Agency	Patuakhali	Field Officer
UNFPA	UN Agency	Sirajganj	Field Officer

Annex II: List of References

Disaster Response

- UNFPA. Bangladesh Country Programme Document 2022-2026. 2021
- UNFPA. Bangladesh Contingency Plan. 2024
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Refugee Response

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Annex III: Bangladesh Country Visit Schedule

Time	Activities	Place
14 February 2025, Friday Arrival at Dhaka Airport (Hotel pick up); 15 February 2025, Saturday Review Documents		
Day 1: 16 February 2025, Sunday (UNFPA Driver, Sogir, 01712860734)		
08:30 – 9:30 am (1 hour)	Thematic FGD with Humanitarian Unit: Mursida, focal point; Naziat, Hum Reporting Officer; Jahan-Programme Associate, GBV cluster: Rumana Khan, GBV Cluster Coordinator; Mili, IMO	UNFPA Satellite Office Gulshan
09.30 - 10:15 am (45 minutes) 10.15 - 11.00 am (45 minutes) 11.00- 11.45 am (45 minutes) 11.45- 12.30 pm (45 minutes)	Focus group discussion with UNFPA Thematic units UNFPA humanitarian response team: max 10 Thematic FGD with SRH Unit: Vibhavendra Raghuyamshi (Chief of Health), Abu Sayed Hasan (SRH Specialist), Animesh Biswas (Programme Specialist-Maternal Health- hum focal point) SRH: CIPRB, Green Hill (will join virtually), LAMB (will join virtually), PHD; (45 mins) Thematic FGD with Gender Unit: Shamima Pervin (Unit chief, Gender), Samsad Khan, GBViE Officer and GBV hum FP, Thematic FGD with A&Y unit: Iliza Azeyi (Programme Specialist, A&Y), Muhammad Munir Hussian (Programme Analyst), Rubina Yeasmin (Programme Officer- hum focal point); Thematic FGD with Operations team (virtually after filed work): Begench Annamuradov (IMO), Al Masum (Finance Officer) - Thematic meeting with M&E and Comms (virtually after filed work): Bobby Rawal, Jefferson Chakma, Abu Raihan (M&E Officer/Consultant), Asma Akhter (Programme Officer, Media and Communication) Thematic meeting with Field Officers (virtually after filed work): Field Officers- Shaheen Akhter (Gaibandha), Kaniz Zahura (Sirajganj), Md Kamruzzaman (Patuakhali), Noor E Alam Siddique (Bagerhat), Timothy Khyang (Bandarban), Md Atahar Ali (Jamalpur), Md Lutfor Khan (Barguna)	UNFPA Satellite Office Gulshan
1:00 - 2:00 pm (1 hour)	Inception Meeting with Unit Chiefs (Programme head of SRH, GBV, A&Y, PD), Masaki, Roselidah, Sachchi, Bobby, Rumana, Asma, Begench-IOM (methodology and expectations)	UNFPA Satellite Office Gulshan
2:00–3:00 pm (1 hour)	Group discussion with selected GBV cluster members : **Action Aid Bangladesh (AAB):** -Mousumi Biswas, Deputy Manager – Women's Rights and Gender Equity **Concern Worldwide:** -Mousumi Sharmin-Gender Coordinator **World Vision:** -Jannatul Tazrin, National Coordinator, **Humanity and Inclusion (HI):** -Rehana Afroz, Protection Technical Specialist, **Manusher Jonne Foundation (MJF):** -Shoma Datta, Programme Manager, **Concerned Women for Family Development (CWFD):** -Arifun Nahar Som, Coordinator-Helpdesk; Rokeya Sultana, Deputy Executive Director **Naripokkho:** -Kamrun Nahar, Member of Naripokkho	UNFPA Satellite Office Gulshan
3:00–4:30 pm 3.00- 3.45 pm 3.45- 4.30 pm	FGD with NGOs, implementing UNFPA humanitarian response interventions: (Online meeting) GBV: ActionAid Bangladesh, Gana Unnayan Kendra (will join virtually) (45 mins) A&Y: Concerned Women for Family Development (CWFD) (45 mins)	UNFPA Satellite Office Gulshan

Time	Activities	Place
04:30 pm	**End of Day 1**	
Day 2		
8:30-9.10 am (40 mins)	Travel to the Australian High Commission to meet with Humanitarian Advisor (interaction for both disaster response and refugee response) Hamah Hosen, Deputy Humanitarian Advisor	Australian High Commission, Gulshan
9.10 - 9.50 am	Travel to the Directorate General of Health Services (DGHS)	
10:00- 11.00 am (1 hour)	Group discussion with Government partners: Deputy Programme Manager- EOC, Programme manager, DGFP (Adolescent health) and Assistant Director, Midwifery	UNFPA Project office, DGHS, Mohakhali
11:10-12:00 pm (50 mins)	FGD with the midwives working in humanitarian response Translator - Shakila	UNFPA Project office, DGHS, Mohakhali
12.00- 12.40 pm (40 mins)	FGD with volunteers who worked on SRH health camp and outreach sessions (5/7 volunteers) Translator - Shakila	UNFPA Project office, DGHS, Mohakhali
12.40- 1.40 pm	Travel back to the UNFPA office and Lunch	
1:40-2:20 pm	FGD with youth volunteers who worked on distribution and adolescent and youth outreach session	UNFPA Office Bangladesh
2.20-3.00 pm	KII with Government Partner: Dr. Prakash K Chowdhury, Joint Secretary, MoWCA and Co-Chair of GBV Cluster	UNFPA Office Bangladesh
3.10-3.50 pm (40 mins)	KII with Government stakeholder: Ahamadul Haque, Additional Secretary (MoDMR) and Director, Cyclone Preparedness Programme (CPP)	UNFPA Office Bangladesh
4.00-4.40 pm	FGD with community women protection volunteers who worked on distribution and community outreach sessions	UNFPA Office Bangladesh
4.40 pm onwards	**End of Day 2, and Travel to Cox's Bazar** **Arrival to CXB: 5:30 pm (UNFPA car will pick up from the airport to the hotel)**	
Day 3		
8:00-9:30 am (1 hour 30 min)	Meeting with CXB team leaders & Humanitarian Team (Carol, Enrica, Laura, Annie, Noyem, Roselidah, Ram, Sachchi/Eshan,)	UNFPA CXB office
9:30-11:00 am (1 hour 30min)	Drive to Camp 11	Refugee Camps Ukhiya
11:10:12:10 am (1 hr)	Focus group discussion with front-line service providers - GBV, A&Y. Translator arranged	Refugee Camps, Ukhiya
12:10-12:30 pm	Travel to Friendship Hospital	Ukhiya
12:30-01:00 pm	FGD with the Friendship Hospital medical staff providing SRH services - midwives, Drs and nurses.	Ukhiya
01:00-01:30 pm	Drive to North End and lunch on the go	Ukhiya
01:30-02:30 pm	Drive back to Cox's Bazaar	UNFPA

Time	Activities	Place
02:45-03:30 pm	Meeting with DDFP	DDFP Office
03:45- 04:30 pm	Meeting with the RRRC	RRRC Office
Day 4		
8:45-9:30 am (45 mins)	UNHCR: Johanna Reina Picaula - Protection Sector Coordinator Livelihood Sector Coordinator: Ashik Kabir	ISCG Office
9:30-10:15am (45 mins)	UNICEF: Child Protection: Tarek Akkad Education: Ralph Zireva	ISCG Office
10:30- 12.00 pm (1.5 hrs)	FGD with UNFPA Coordination teams - Dr. Carolyn Nalugwa (SRHWG Coordinator); Annie Waweru (GBVSS Coordinator); Laura Brandao (YWG Co-coordinator)	UNFPA Office
12:15 - 13:15 pm	Meeting with David Budgen (ISCG Coordinator)	ISCG Office
01:15- 02:15 (1 hr)	Lunch	UNFPA Office
03:00- 04:30 pm (1 hr 30 mins)	FGD with UNFPA implementing partners - 1 representative from each of the IPs including OCC representatives.	UNFPA office
06:25 -07:30 pm	Flight out of CXB	CXB - Dhaka
Day 5		
9:00-10:00 am (1 hour)	FGD with organizations working with gender-diverse people and key population groups (Bandhu, Prerona, GUK, CWFW)	UNFPA Satellite Bangladesh office, Gulshan
10:00-11:00 am (1 hour)	FGD with transgender group supported by UNFPA during flood	UNFPA Satellite Bangladesh office, Gulshan
11:00 –12:00 pm (1 hour)	FGD with organizations working on forecast-based Anticipatory Action (WFP, Unicef, FAO, BDRCS, Needs Assessment Working Group)	UNFPA Satellite Bangladesh office, Gulshan
12:00-12:45 pm (45 mins)	Key informants interview with Ms. Aleyda Valdes, Humanitarian Affairs Advisor	UNRC Office
12:45-3:00 pm (2 hrs 15 mins)		
3:00-4:30 pm (1 hour 30 mins)	**Evaluator debriefing meeting with Representative a.i Masaki Watabe, unit chiefs, and other UNFPA staff who participated in interview/focus group discussion sessions**	UNFPA Satellite Bangladesh office, Gulshan
4.30 pm	**End of the evaluation field mission**	

Driving evidence-based actions

Ensuring rights and choices for all

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