Deliverable 7

REPORT ON

ENDLINE EVALUATION OF WOMEN-LED CLIMATE RESILIENCE PROJECT (WLCRP)

Submitted To

PATHFINDER

Submitted By

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
API	Application Programming Interface
AYSRH	Adolescent and youth sexual and Reproductive Health
BCC	Behaviour Change Communications
BEmONC	Basic Emergency Obstetric and Newborn Care
BMRC	Bangladesh Medical Research Council
BRCS	Bangladesh Red Crescent Society
CAC	Comprehensive Abortion Care
CC	Community Clinic
CCVI	Climate Change Vulnerability Index
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHW	Community Health Workers
CMR	Clinical Management of Rape
CO2	Carbon Dioxide
CS	Caesarean Section
DDM	Department of Disaster Management
DDMC	District Disaster Management Committee
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DNA	Deoxyribonucleic Acid
DPT	Diphtheria, Tetanus, & Pertussis
DSHE	Directorate of Secondary and Higher Secondary
EONC	Essential Obstetric and Newborn Care
FGD	Focus Group Discussion
FIVDB	Friends in Village Development Bangladesh
FP	Family Planning
FSCD	Fire Service and Civil Defense
FWV	Family Welfare Visitor
GBV	Gender-based Violence
Hep B	Hepatitis B
HF	Health Facility
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HTS	HIV Testing Services
ID	Identification
IDI	In-depth Interview
IEC	Information, Education, and Communication
IPC	Infection Prevention and Control
IPV	Inactivated Poliovirus Vaccine
IUD	Intrauterine Device
KAP	knowledge, Attitudes, and Practices
KII	Key Informant Interview
MCH	Maternal and Child Health
MCRAH	Maternal, Child, Reproductive and Adolescent Health

MCWC	Mother and Child Welfare Center
MEL	Monitoring, Evaluation, and Learning
MISP	Minimum Initial Service Package
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOWCA	Ministry of Women and Children Affairs
MVA	Manual Vacuum Aspiration
N_2O	Nitrous Oxide
NCD	Non-communicable Disease
NGO	Non-governmental Organization
NSV	No Scalpel Vasectomy
PAC	Post Abortion Care
PNC	Postnatal Care
POPI	People's Oriented Program Implementation
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intrauterine Contraceptive Device
RD	Rural Dispensaries
RMNCH	Reproductive, Maternal, Newborn, and Child Health (RMNCH)
SAM	Short-Acting Method
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UDMC	Union Disaster Management Committees
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
VIA	Visual Inspection with Acetic Acid Wash
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WLCRP	Women Led Climate Resilience Project
YPSA	Young Power in Social Action

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Executive Summary

Background: Bangladesh's haor and disaster-prone districts face recurrent floods, supply disruptions, and constrained access to SRHR/MNCH care. WLCRP ("Dishari") responded by coupling women's leadership with health-systems resilience to keep essential services running during shocks. Implemented by Pathfinder with FIVDB, POPI and YPSA (2022–2025) across Sylhet, Sunamganj, Kishoreganj, Netrokona, and Cox's Bazar, WLCRP engaged 924 women's groups, 500 resilience volunteers, 40 schools, 68 UDMCs and 571 facilities, aligning with DGHS, DGFP, DDM, DSHE, FSCD and MOWCA. The project goal was to ensure reliable access to quality care for women and girls and stronger system resilience. The endline evaluation aimed to assess outcomes in community empowerment (knowledge, agency, leadership), service continuity and facility preparedness (MISP/GBV integration, emergency readiness), and collaboration/learning for policy influence, measuring change from baseline and triangulating system outputs with user experience.

Methodology: The endline combined three components: (1) Health Facility Readiness Assessment; (2) Climate Champion awareness/agency assessment; and (3) Community perspectives and implementation experience. HDRC secured IRB approval; tools were translated and piloted. Data were captured via CAPI with daily uploads, a codebook, cleaning logs, and consistency checks. Supervisors verified entries; enumerators completed multi-day training, mock tests, and field tests; local enumerators were used in Cox's Bazar. Quality control included random spot-checks, re-scrutiny of questionnaires, and dataset verification prior to analysis. Limitations (facility closures, flood-restricted access, incomplete records) were mitigated through replacements and triangulation across sources. Analysis linked changes at facility level (governance, supplies, protocols, human resources, emergency preparedness) to utilization and continuity outcomes, and integrated qualitative narratives to explain variance. The survey covered 102 health facilities across four districts and 106 resilience volunteers. Qualitative data were gathered through 25 KIIs with health providers, 5 FGDs with resilience volunteers, and 10 IDIs, along with 22 KIIs and 17 FGDs with community members, local leaders, and project staff. Secondary document reviews included baseline reports, annual progress reports, gender and disaster toolkits, and training manuals.

Findings:

WLCRP's integrated outputs (training, drills, champions, planning tools, SMS, supervision) consistently produced outcomes (higher facility readiness and service uptake; improved GBV/CMR/HTS availability; greater women's agency and preparedness behaviors; earlier evacuation and maintained SRHR/MNCH continuity) at or above targets—evidence of a scalable, systems-anchored model for climate-resilient primary care.

WLCRP's community-facing outputs—20508 health communication events, 1332 gender dialogues, 500 (220 female) trained Climate/Resilience Champions, and 1.265M people reached (including 778,678 SMS)—produced measurable outcomes in women's agency and service use. Climate Champions reporting agency increased from 87% to 95%, recent health-service use from 62% to 73%, and favorable FP attitudes from 92% to 99%; 4,655 people adopted new livelihoods (931% of target), linking income stability to care-seeking during floods. Champions and UDMCs reported earlier evacuation, storing dry food and medicines, and using hotline 1090 for warnings. "Before the project, women and girls rarely participated… now they are included in committees," noted a Netrokona UDMC; daughters began using sanitary pads and IFA, and school attendance during menstruation improved. These changes are directly tied to WLCRP's behavior-change sessions, SMS, and UDMC/school linkages.

Climate Champions successfully achieved all outcomes, such as self-efficacy increased from 93% to 97%, agency from 87% to 95%, SRHR/MNCH/WASH knowledge from 95% to 96%, favorable FP attitudes from 92% to 99%, and recent health-service use also increased from 62% to 73%, driven by 500 trained volunteers (44% women) delivering thousands of cascading sessions and activating early warnings/evacuations. These gains are expected to yield thousands of additional ANC/PNC and FP

contacts during flood months, earlier GBV/CMR care within 72 hours, faster evacuation and safer sheltering, and quicker referral for seasonal risks (e.g., snakebite)—together reducing missed care and preventable complications while reinforcing women's leadership in local disaster governance.

On the health-system side, WLCRP outputs—2,766 providers trained (GBV/CMR, MISP, IPC, adolescent SRH, snakebite), supervisory visits, job-aids, and facility drills—translated into service continuity and readiness outcomes. Facilities prepared for shocks reached 571 (135%); 571,391 people received services/support (158%); and 571 facilities showed increased uptake of SRHR/MNCH services (154%). Readiness improved across tiers: CMR-trained providers 24/7 increased to 90.9% (UHCs) and 73% (UHFWCs); HTS provider availability emerged where it was zero at baseline (e.g., 50% MCWCs). A paired analysis of Emergency Preparedness Scores across 102 facilities shows a +9.84-point mean gain ($p<0.001$), with UHCs 79.4 vs 57.4 at baseline. Providers describe tangible shifts—pre-positioned stocks, referral logs, and adolescent corners keeping FP/ANC/PNC running through floods: "nurses were deployed in shelters to serve adolescent girls and women," reported Hatkhola, Sylhet. These outcomes are attributable to WLCRP's training and supervision package and integration with government SOPs.

Governance and collaboration outputs—544 planning mechanisms with health/gender integrated (436 facilities, 68 UDMCs, 40 schools) and 12 regional learning events—shifted institutional practice. UDMCs that were "not very active" now meet regularly, run mock drills, and coordinate boats, shelter management, and pre-stocked kits; women's membership on one UDMC increased from 7 to 9. Implementing partners cite checklists, street drama, school councils, and linkage workshops as catalysts for durable coordination across UPs, fire service, and health departments. These outputs yielded outcomes of faster warnings, earlier movement to shelters, and fewer facility closure days during 2024–2025 floods, as narrated in Sunamganj/Netrokona/Cox's Bazar cases.

A focused case is snakebite, a haor-season surge risk. WLCRP trained 137 providers on snakebite first aid and management, added protocols, and ran community awareness. KIIs report reduced mortality and a shift from traditional healers to facilities: "since implementing the training, the mortality rate from snakebites has decreased," said Mithamoin UHC; "during floods, snake infestation increases… we now provide proper first aid," echoed Hatkhola, Sylhet. This pathway—training + referral + public messaging—demonstrates how a targeted output set produced an outcome of safer, timelier care during climate shocks.

Major learnings

- Women-led community structures keep services running during shocks. Where women's groups, student councils, and UDMCs were activated and linked to facilities, households moved earlier, brought essential items/meds, and kept using SRHR/MNCH services through floods. This reduced service interruptions and improved adolescent and maternal care-seeking.
- MISP/GBV integration ensuring supervision changes frontline behavior fast. Targeted training, job aids, and supervisory follow-ups translated into more consistent CMR, referral logging, and adolescent-friendly services—even in lower-tier facilities.
- Peripheral governance fixes drive the biggest gains. Simple accountability mechanisms—preparedness checklists, stock logs, on-call rosters, and data verification—moved the needle most at CCs/UHFWCs.
- Targeted clinical priorities (e.g., snakebite) demonstrate rapid improvement. Focused protocols and drills around predictable seasonal risks improved timeliness of care and confidence to treat locally.

Recommendations

1) Institutionalize preparedness financing and a Minimum Resilient Services Package (MRSP). Create ring-fenced budget codes at UHC/UHFWC/CC and Union Parishad levels for emergency drug kits, power backup, boat/water-ambulance hours, and minor repairs; adopt an MRSP for SRHR/MNCH/GBV during shocks (defined contents, staffing, referral/data steps). Lead actors for this can be MoHFW (DGHS/DGFP), LGD/UPs, DDM, Finance Division; Civil Surgeons/UHFPOs.

2) Make MISP/GBV/CMR an annual competency with light-touch supervision. Institutionalize a 1-day annual refresher for MISP, GBV/CMR, adolescent SRH, trauma basics and snakebite, embedded in routine supervisory visits using a 10-point checklist (readiness, on-call roster, referral tests, data verification). Lead actors can be DGHS/DGFP training units, Nursing & Midwifery Council, Civil Surgeons/UHFPOs; Pathfinder/partners for tech backstopping.

3) Deploy "predictable-risk bundles," starting with snakebite, backed by supply redundancies. Package protocols (first aid, triage, antivenom indications), antivenom logistics, community trigger messages, and pre-monsoon drills that pair facilities with communities; add lightning and drowning micro-modules where relevant. In parallel, protect continuity with a two-month buffer of SRHR/MNCH essentials at UHC/UHFWC, mapped secondary delivery routes (boats/local depots), and a shared outage board (power, water, cold-chain) with escalation contacts. Lead actors may include DGHS clinical directorate, Civil Surgeons, FSCD (drills), CMSD/DGFP logistics, UPs for transport, local media for PSAs.

4) Lock in women's and youth leadership inside formal disaster governance. Include women leaders/teachers/students on UDMC/SDMCs; formalize volunteer cadres (ID cards, first-aid kits, visibility gear, micro-stipends during emergencies); align school disaster clubs with facility drills and maintain seasonal SMS/IVR nudges (hygiene, ANC/PNC, GBV help-seeking, safe sheltering). Lead actors for this can be DDM/UDMCs, MoWCA, DSHE, Upazila administration, local NGOs.