

Endline Assessment Report

Improving Sexual and Reproductive Health and Rights in Dhaka



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Abbreviations

ANC	Antenatal care
BMRC	Bangladesh Medical Research Council
CAG	Community action group
CNG	Compressed natural gas
DNCC	Dhaka North City Corporation
DSCC	Dhaka South City Corporation
FP	Family Planning
GBV	Gender-based violence
GP	General practitioners
HIV	Human Immunodeficiency Virus
ISRHRD	Improving Sexual and Reproductive Health and Rights in Dhaka
IUD	Intra Uterine Devices
MDG	Millennium Development Goals
MR	Menstrual regulation
MRM	Menstrual regulation with medication
NCC	Narayanganj City Corporation
NIHORT	National Institute of Population Research and Training
PAC	Post-abortion care
SDG	Sustainable Development Goals
SGBV	Sexual and gender-based violence
SPSS	Statistical Package for Social Sciences
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STD	Sexually transmitted diseases
ToR	Terms of Reference
UPHCSDP	Urban Primary Health Care Services Delivery Project
WHO	World Health Organization

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Executive Summary

Background:

This endline assessment has been conducted as part of the Improving SRHR in Dhaka project (May 2021 to Sep 2026), implemented by the HealthBridge Foundation of Canada in partnership with Ipas Bangladesh, BAPSA, RHSTEP, OGSB, and SERAC Bangladesh, with funding from Global Affairs Canada. The endline assessment evaluated the effectiveness of the community-based intervention aimed at improving SRHR knowledge, attitudes, and service utilization among women and adolescent girls in underserved urban areas of Dhaka (Dhaka City Corporation areas), Bangladesh. The assessment also compares baseline and endline findings to measure changes across five key domains: i) knowledge and awareness regarding SRHR, ii) attitudes and beliefs, iii) enablers and barriers of accessing SRH services, iv) appropriateness of project's community events and v) perceived learning and influence on service-seeking behavior.

Methodology:

A cross-sectional quantitative survey was conducted among 525 women and adolescent girls who had attended project activities in the past 18 months prior to data collection, complemented by additional questions on service utilization and community engagement. Data was collected through face-to-face interviews using a semi-structured questionnaire in KoBo toolbox. Descriptive analysis was performed using SPSS to compare findings between baseline and endline.

Findings:

Knowledge and Awareness: Knowledge of family planning methods was nearly 100% at endline, with awareness of at least four modern methods well exceeding the project target of 60–70%. MR/MRM awareness was high at both baseline (87.9%) and endline (84.6%). Outreach workers, community volunteers and GPs emerged as the most frequently cited sources of information for both family planning and MR. Awareness of where to access both family planning and MR services reached near-universal levels at endline sufficiently meeting project targets.

Attitudes and Social Norms: Perceptions of MR as a safe procedure shifted substantially (35.2% to 79.1%), and community support for making MR more accessible remained high and increased further at endline, indicating the project activities not merely increased awareness but a deeper attitudinal transformation. Support for the legal minimum age of marriage was high at both time points and strengthened further at endline, with the large majority of respondents endorsing 18 years as the minimum age for girls and 21 years for boys. Joint decision-making between spouses improved considerably across all three reproductive health domains - childbearing decisions, contraceptive use, and MR - reflecting a meaningful rebalancing of household power dynamics and progress toward more gender-equitable norms.

Barriers and Access: The majority of respondents reported no barriers at the endline in accessing SRH services, and perceived ease of access improved across multiple dimensions, including transportation, clinic timing, and ability to attend services independently. A particularly encouraging finding was the substantial increase in the proportion of respondents reporting the ability to attend a health visit independently, reflecting improved autonomy in reproductive health decision-making.

Community Perspectives on SRHR Awareness Sessions: Community discussion events were widely accepted, well-attended, and positively regarded by participants. The majority (88%) found the sessions useful and easy to understand, and satisfaction with timing, location, and facilitation was similarly high. Among those who reported difficulty, environmental distractions, i.e., noise, rather than content complexity or facilitator quality, were cited as the primary barriers, pointing to logistical rather than programmatic shortcomings. Participants reported gaining knowledge across a broad range of SRHR topics, with family planning, MR, menstrual hygiene, and pregnancy care most prominently cited. Almost all participants reported some level of increase in SRHR awareness, and the large majority indicated that the sessions positively influenced their own or their peers' ability to access SRH information or services.

Discussion and Conclusion

The endline assessment findings suggests that the ISRHRD project contributed to improved SRHR awareness, perceived access to services, and more gender-equitable attitudes among women and adolescent girls in underserved urban areas of Dhaka. Through community outreach, volunteer engagement, provider training, pharmacy engagement, and social media awareness activities, the project appears to have strengthened access to SRHR information and services at the community level.

Awareness of modern family planning methods increased substantially, while attitudes toward MR became more positive. Respondents increasingly identified volunteers, outreach workers, pharmacies, hotlines, and social media as important sources of SRHR information. Improvements were also observed in women's autonomy and joint decision-making related to contraception, childbearing, and MR.

The findings further indicate increased use of GP services, likely reflecting the project's support to strengthen community-based SRHR service provision. However, continued demand for SRHR information suggest the need for ongoing community education and engagement.

The findings overall suggests that integrated community-based SRHR interventions can play an important role in improving awareness, autonomy, and access to SRHR services among underserved urban populations.

Introduction

Sexual and reproductive health and rights (SRHR) have been regarded solely as isolated health concerns for a long time, without acknowledging their crucial role in individuals' overall health and wellbeing (1). Sexual and reproductive health (SRH) is the state of complete well-being of individuals in relation to their sexuality and reproductive system, encompassing physical, mental, emotional, and social aspects (2). Meanwhile, SRHR aims to safeguard against discrimination, coercion, and violence, while also promoting access to the highest quality of reproductive health care (3,4). However, globally, SRHR remain challenged by persistent inequities. Nearly 4.3 billion individuals of reproductive age experience inadequate access to SRHR care(1). Each year, an estimated 25 million unsafe abortions occur(1) and one in three women experiences intimate partner or sexual violence (5) . Additionally, over 200 million women in low- and middle-income countries express a desire to avoid pregnancy but lack access to modern contraceptive methods (6).

With a population of 173 million, Bangladesh is the world's 8th most populous country and continues to struggle with significant SRHR challenges despite remarkable advancements. Approximately three out of every five Bangladeshi girls are married before the age of 18, contributing to one of the highest adolescent fertility rates globally (7). Although total fertility has declined over recent decades, the rate has plateaued at 2.3, with a persistent unmet need for contraception, particularly long-acting reversible and permanent methods (8). Coverage of essential maternal health services remains low. Only 41% of pregnant women attend four or more antenatal care (ANC) visits, and 21% receive quality ANC (9). Although Bangladesh has made significant progress in reducing child mortality, improvements in neonatal survival have lagged, and this accounts for more than 60% of all under-five deaths (10). These trends underscore critical gaps in the SRHR agenda in Bangladesh and the urgent need for locally grounded, evidence-based solutions.

The United Nations Sustainable Development Goals (SDGs) represent a universal, integrated, and transformative vision for a sustainable world concerning SRHR. SRHR is critical for sustainable development due to their links to women's well-being, their impact on maternal, newborn, and adolescent health, and their roles in shaping future economic development and environmental sustainability (1). At the core of the 2030 agenda is a list of 17 Sustainable Development Goals (SDGs) to end poverty, hunger, and inequality; two targets (3.7 and 5.6) were outlined specifically to address sexual and reproductive health, ensuring that SRHR remains a priority on the global development agenda (1). Although Bangladesh has already met a few SDGs so far, it is still facing significant challenges in achieving 14 SDGs related to SRHR.

Project overview

HealthBridge Foundation of Canada, along with its partners (Ipas Bangladesh, BAPSA, RHSTEP, OGSB, and SERAC Bangladesh) has been implementing the Improving Sexual and Reproductive Health and Rights in Dhaka (ISRHRD) project

(May 2021 -Sep 2026) funded by Global Affairs Canada, focusing on improving SRHR in underserved urban areas in Dhaka. The project has a particular focus on adolescents, unmarried women, and ready-made garment factory workers. The overall goal of the project is to improve the SRHR of underserved and vulnerable women and adolescents in Dhaka.

The project's intermediate outcome is the increased use of SRH services that uphold the rights of women and adolescent girls and address the needs of vulnerable groups living in urban slums, including in times of crisis. Its immediate outcomes are: i) Improved availability of and access to quality SRH services for women and adolescents in urban slum areas; ii) Increased social support, knowledge, and self-efficacy related to SRHR, including sexual and gender-based violence (SGBV) resources for slum women and adolescents; and iii) Improved public health emergency preparedness and response to ensure access and uninterrupted delivery of essential SRH services and supplies during public health emergencies, including pandemics such as COVID-19.

The project initially planned to work with 9 referral hospitals, 30 Urban Primary Health Care Services Delivery Project (UPHCSDP) clinics, 100 General Practitioners (GPs), and 15 garment factory clinics to expand access to quality SRH services. As the project progressed, additional needs were identified, leading to the inclusion of more health facilities. By the end of the project, support had expanded to a total of 169 health facilities, including 12 referral health centres, 42 UPHCSDP centres, 15 garment factory clinics, and 100 GPs.

The project support included training healthcare workers to deliver family planning, menstrual regulation (MR), post-abortion care (PAC), and SGBV services. It also supported provider skill upgrading, mentoring, and supportive supervision, while ensuring the consistent availability of SRH commodities.

At the community level, the project leveraged a network of 1,000 volunteers, 100 Community Action Groups (CAG), and outreach health workers to create demand for SRH services. This is achieved through awareness-raising activities such as community and courtyard sessions, school-based activities, and local campaigns on key SRHR topics.

Objective and scope of the endline assessment

The endline assessment focused on the impact of project activities at the community level and was conducted among the individuals who participated in the project activities. It included a survey with women and adolescent girls to measure changes in their knowledge and attitudes about SRHR, as well as their access to related services. Additionally, the assessment reviewed the relevance and quality of the community-based events and explored whether the disseminated information supported participants in seeking SRH information and/or services.

Specific objectives

1. To assess changes in knowledge and awareness among the women of reproductive age who have been reached by the project related to SRHR information and services, including family planning, menstrual hygiene, MR, PAC, and SGBV.
2. To assess changes in attitudes and beliefs about early marriage and pregnancy, family planning, MR, PAC, and SGBV among the women of reproductive age who have been reached by the project.
3. To explore changes in the enablers and barriers in accessing and utilizing SRHR information and quality SRHR services among women of reproductive age and adolescent girls who have been reached by the project.
4. To assess the appropriateness of the project's community-based events—including content, delivery methods, timing, location, inclusiveness, safety/comfort, and facilitation.
5. To explore participants perceived learning and key takeaways from the events, including what was new, most helpful, or most memorable.
6. To understand whether the information from the events influenced participants' ability to seek SRH information or support/services.

Methodology

Study design, setting, and population

Study design: The study was cross-sectional in nature. The survey involved a semi-structured questionnaire focusing on awareness and knowledge of SRHR issues, access to information, perceived SRHR needs and priorities, access to services, and healthcare-seeking behavior. In addition, some supplementary insight was collected to understand the project participants' views regarding the community sessions. Apart from the quantitative survey, relevant documents were reviewed, such as the baseline study report, peer-reviewed journal articles, and working reports¹.

Study area: The endline assessment took place in the underserved urban areas of Dhaka North City Corporation and Dhaka South City Corporation, where the community sessions were organized as a part of the project.

Population: The study participants were women and adolescent girls who had attended at least one project community session within the last 18 months before the assessment. A list of those project participants, including their contact information and locations of community events, was provided by the project team.

¹ On universal access to sexual and reproductive rights: Bangladesh, prepared by Naripokkho and SIDA

Sample size and sampling procedure

Determination of sample size: The sample size was calculated using a single-sample prevalence estimate to assess outcomes among attendees only. The parameters used were:

- Design Effect (DE) = 1.6
- Margin of Error = $\pm 5\%$ at 95% Confidence Interval
- Baseline estimated proportion (p) = 0.713

Using the standard formula:

$$n_0 = \frac{Z^2 \times p(1 - p)}{d^2} \times DE$$

Where $Z = 1.96$ for a 95% confidence level and $d = 0.05$. The calculated sample size is approximately 525 participants. The project has reached approximately 30,000 participants to date (17,000 in the past 18 months), so the total population size has minimal impact on the sample size and was not included in the calculation.

Sample distribution: A stratified random sampling approach was used to select respondents, ensuring that the sample remains proportional to the number of participants in both DNCC and DSCC. The total sample was distributed proportionately in two city corporation areas based on the number of participants in the intervention wards of these two city corporations.

City corporation	Number of participants	Sample size
DNCC	4412	316
DSCC	2914	209
Total	7326	525

To ensure representation of all major areas of DNCC and DSCC, these entire study areas were divided into nine zones, and the sample was divided into these zones based on the number of participants in these zones.

City Corporation	Zone	Number of participants	Sample size
DNCC	Total	4412	316
	Mohammadpur	1196	86
	Mirpur, Gabtoli, Kollyanpur, Vasantake	1897	136
	Uttara	383	27
	Aftabnagar, Badda	252	18
	Mohakhali	684	49

City Corporation	Zone	Number of participants	Sample size
DSCC	Total	2914	209
	Azimpur, Hajaribag, Old dhaka	961	70
	Khilgagon, Basabo, Madartek	951	68
	Jatrabari, Shaniakhra, Demra	481	34
	Maninknagar, Gupibag, Shahjahanpur, Monda	521	37

Sampling procedure: A systematic random sampling approach was used to select respondents from the list of all individuals who participated in at least one community session in the past 18 months. The list of participants includes their contact information, such as name, phone number, and specific location of community events (ward, city corporation name). The consultant team contacted individuals who were randomly selected from this list and invited them to take part in the survey. Those who agreed to participate were offered the option of an in-person interview at a location of their choice.

The complete participants list was first organized by zone. Each participant was then assigned a unique identification number (in the hard copies of the list provided by project officials). After finalizing the zone-wise lists, respondents were selected at a fixed interval of five (i.e., every 5th participant). In cases where a selected participant could not be reached or interviewed for any reason, the immediately preceding or following individual on the list was approached as a replacement.

Data collection period: Data was collected at the field level from 6 March to 16 March 2026.

Implementation strategy

Questionnaire development: For the quantitative survey, the baseline survey questionnaire was used so that endline data can be compared with the baseline. Since a similar questionnaire was used, pilot testing is not required. In addition to the baseline survey questionnaires, some supplementary questions were included to capture participants' level of participation, perceptions of the project activities, and other relevant topics.

Recruitment and training of field investigators: The consultants recruited six enumerators and two supervisors who have a good understanding of the local context and languages (Bangla) to smoothly conduct the survey and to complete all the tasks within the stipulated timeframe. The study team arranged a 2-day intensive training, which included in-house orientation and repeated simulation practice sessions. The training outline and data collection team details can be found in Annex 1.

Monitoring and supervision

The monitoring plan established a comprehensive framework to ensure quality assurance, accountability, and systematic tracking of all phases of this endline study. To maintain the highest level of research integrity, the monitoring plan tracked implementation progress against the work plan and deliverables while ensuring adherence to ethical considerations, approved methodology, and quality standards. Monitoring activities vary in focus and intensity across the four phases of the endline assessment.

i) Inception and Desk Review

During the inception phase, emphasis was on document review, sampling design, tools development, and preparation of the inception report. Monitoring actions during this phase included internal review of the inception report against Terms of Reference (ToR) requirements to ensure all elements were addressed before submission, formal submission to HealthBridge for feedback and approval, with incorporation of any requested revisions.

ii) Field Data Collection

Daily monitoring involved continuous tracking of the data collection progress. Field supervisors assessed enumerator productivity and data quality using digital dashboards that highlight completion rates, errors, and geographic coverage. Supervisors verified field presence through Global Positioning System (GPS) tagging. Digital data collection was powered by the KoBo Toolbox that integrates GPS tagging, ensuring real-time visibility into progress and data quality.

Fieldwork quality assurance procedure

Each investigation team was guided by one field supervisor who maintained contact with the consultant office on a day-to-day basis on the progress of data collection. The field supervisor was responsible for ensuring supervision and management of the team at the field level.

Consultants tracked performance, implementation, data transmission, and data quality throughout the survey. Any observed issues were promptly addressed. We used two quality assurance systems during fieldwork: online data collection applications and field supervision to monitor the quality of data collection.

a. ***Online data collection applications:*** The Kobo toolbox that interviewers used to collect data was also designed to help interviewers check responses for consistency and for plausibility. When there was a consistency issue, the application prompts interviewers to probe and to correct whichever variable is incorrect (as appropriate). When there was a problem with plausibility, a warning message suggested that the interviewer double-check the answers they were given. The data analyst checked the data regularly and notified the field supervisors and enumerators to take the necessary measures.

- b. **Field supervision:** Rigorous field supervision was provided throughout fieldwork by several layers of supervisory staff to ensure the quality of the data. Front-line data quality assurance in the field will be provided by the field supervisors. They also spot-check a random sample of interviewed households and provide additional instructions to interviewers as needed. Key consultants visited the field teams during fieldwork to provide supervision and additional quality assurance.
- c. Consultants continuously monitored implementation progress, call disposition patterns, interview duration, data transmission, and data quality indicators. Any irregularities—such as unusually short interviews, high refusal rates, or inconsistent responses—were promptly investigated. Corrective guidance was provided where necessary.

iii) Data Analysis and Interpretation

The monitoring actions during the analysis phase involve a daily review of progress against the work plan to ensure timely completion. Since data were collected through the Kobo toolbox, we could see the live update there and monitor the progress. Both Bangla and English language were available in the Kobo platform.

Data Management Procedure

Quantitative data cleaning and data screening: Data were directly imported from the Kobo toolbox as Excel format and then transformed to Statistical Package for Social Science (SPSS), version 25 for cleaning and analysis. Data cleaning procedure encompasses a two-step process, including DETECTION and then CORRECTION of errors in a data set. A data analyst looked at the common sources of errors, such as missing values, typing error, inconsistency of data, column shift, coding errors, etc. Some steps followed for identifying common errors in datasets:

- Looking at minimum and maximum values (range) for descriptive statistics
- Looking for 0's and 999's (or 9999...etc). This normally uses the maximum permissible values. using descriptive or graphs/ histograms.
- Looking for LIKELINESS OF A VALUE in terms of range.
- Looking at MEANS, MEDIAN, and STANDARD DEVIATIONS.
- Logic check: Errors in data can be checked simply by seeing if the responses are logical. For example, we would expect to see 100% of responses, not 110%.

Data were coded or recoded based on study objective (for example, the age of respondents was recoded into different age brackets), followed by an appropriate data transformation technique, i.e.; combining data into a new variable, data computation, etc.

Data analysis: Quantitative data were analyzed by using SPSS in light of the study objectives. Data has been presented in both tabular format and graphical presentation i.e., bar chart, pie chart, etc., as required. In case of open-ended questions, data were

checked and cleaned carefully in light of the relevance of the questions asked. For categorical variables, descriptive statistics were presented as frequency (percentage).

Ethical consideration

Consultants followed the “HealthBridge Ethics Guidance Note for Research, Monitoring, Evaluation, and Assessment Activities” and the Bangladesh Medical Research Council (BMRC) ethical guidelines for the entire assessment. Ethical approval was obtained from the BMRC (Ref: BMRC/NREC/2019-2022/150) on 26/05/2022. Following changes to the sampling method and the addition of supplementary survey questions at the endline, an amendment was submitted and approved (Ref: BMRC/ERC/2025-26/1002) on 04/03/2026.

The objectives of the research were clearly explained to the participants. Written informed consent, signature, or thumbprint, whichever is suitable, was taken from the participants. Since our research also involved adolescents aged 15-19, we took assent from the adolescents and additional informed consent from their parents or legal guardians whenever required. To ensure that the study is designed and conducted to respect and protect the rights and welfare of the people and communities involved and to ensure that the assessment is technically accurate and reliable, the research ethics followed during the assessment include:

- Avoid causing any kind of physical, social, economic or psychological harm as a result of the research;
- Clearly explain the study objectives to all the respondents before collecting data from them;
- Obtain written consent from those who take part in the research;
- Maintain gender sensitivity in every part of the research;
- Avoid all kinds of prejudices, terms, languages which are likely to humiliate any community, group of believers, or segment of society;
- Respect the anonymity of the research participants;
- Names and personal identification not to be used in quotes and other findings;
- Highly committed to the respondents to keep the privacy of their information and source of data, as well as putting their utmost efforts to be unbiased in collecting data.

Data safeguarding and handling

All raw data collected through physical surveys were securely handled throughout the entire data lifecycle. Data were collected using password-protected Kobo Toolbox accounts.

Access to raw datasets was strictly limited to authorized personnel, including the data manager and designated analysts. Personally identifiable information was stored separately from survey response data and replaced with unique identification codes prior to analysis to ensure confidentiality.

All data handling procedures complied with the project’s ethical guidance note and applicable data protection standards, and no identifiable information was shared with unauthorized parties.

Findings

The study findings section summarizes the quantitative survey findings. The baseline and endline surveys included 420 and 525 participants, respectively. Both surveys are independent cross-sectional studies. The quantitative survey findings have been organized according to the study objectives as stated in the ToR. Findings have been organized into six major sub-sections: demographic characteristics of study participants, knowledge and awareness regarding SRHR, attitudes and beliefs towards SRHR, enablers and barriers in accessing SRH services, appropriateness of community events, perceived learning, and influence on service-seeking behavior. The endline survey data have been compared with the baseline data.

Demographic information

The majority of participants in both surveys were aged 19–35 and were married (Table 1). Among married women, a notable proportion reported first marrying between the ages of 9 and 14 - 38.4% at baseline and 25.3% at endline. Literacy rate was higher among endline respondents. In both surveys, looking after the family and household was the most commonly reported occupation, cited by 51.0% of baseline and 57.9% of endline participants.

Table 1: Demographic profile of the study participants

Characteristics	Baseline (n = 420)	Endline (n = 525)
	n (%)	n (%)
Age in years		
15-18	57 (13.6)	80 (15.2)
19-35	270 (64.3)	300 (57.1)
36-49	93 (22.1)	145 (27.6)
Marital status		
Divorced (legal)	4 (1.0)	2 (0.4)
Married	365 (86.9)	447 (85.1)
Separated	10 (2.4)	0 (0.0)-
Single	32 (7.6)	50 (9.1)
Widowed	9 (2.1)	26 (5.0)
Age of first marriage*		
9-14	148 (38.4)	120 (25.3)
15-18	189 (48.7)	308 (64.8)
19-35	50 (12.9)	47 (9.9)
Age of spouse while get married*		
10-14	3 (0.8)	1 (0.2)

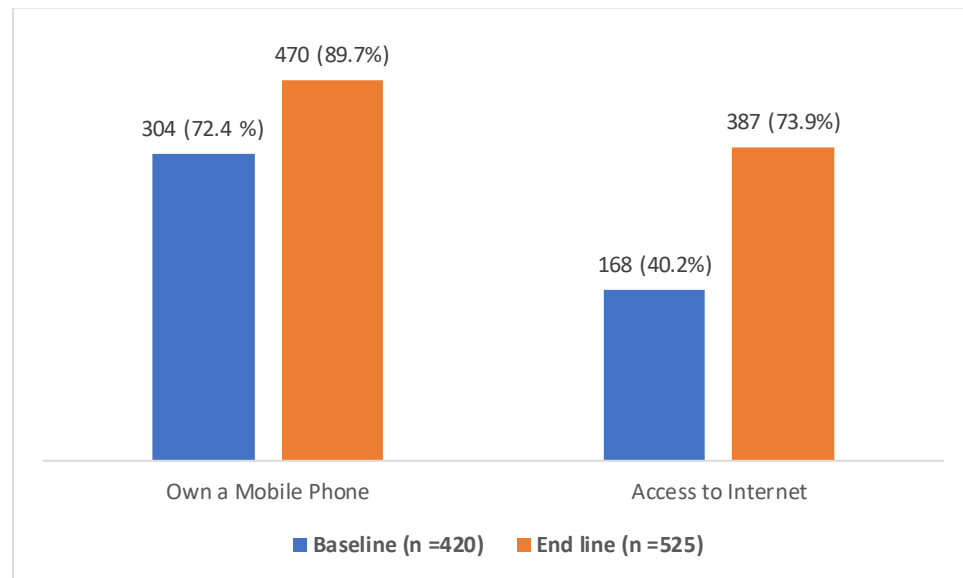
Characteristics	Baseline (n = 420)	Endline (n = 525)
	n (%)	n (%)
15-21	152 (39.2)	211 (44.4)
22-35	224 (57.7)	262 (55.2)
36-49	9 (2.3)	1 (0.2)
Number of children*		
None	37 (9.54)	34 (7.16)
1-2	245 (63.15)	290 (61.05)
3-5	100 (25.78)	147 (30.95)
6-8	6 (1.55)	4 (0.84)
Ability to read and write		
Can't read and write	133 (31.7)	112 (21.3)
Fair	212 (50.5)	330 (62.9)
Good	75 (17.9)	83 (15.8)
Level of education		
No Education	126 (30.0)	106 (20.2)
Primary school	167 (39.8)	221 (42.1)
Secondary school	108 (25.7)	167 (31.8)
Higher secondary school	13 (3.1)	21 (4.0)
College/ University	6 (1.4)	10 (1.9)
Education level of spouse*		
No Education	143 (36.9)	111 (21.1)
Primary school	128 (33.0)	204 (38.9)
Secondary school	100 (25.8)	128 (24.4)
Higher secondary school	10 (2.6)	20 (3.8)
College/ University	7 (1.8)	12 (2.3)
Occupation		
Looking after the family and household	214 (51.0)	304 (57.9)
Part-time paid worker (including daily laborer)	123 (29.3)	128 (24.4)
Full-time paid worker	34 (8.1)	28 (5.3)
Full-time education at school, college, or university/Student	21 (5.0)	40 (7.7)
Business	15 (3.6)	8 (1.5)
Unemployed	11 (2.6)	3 (0.6)
Fully retired from paid work	0 (0.0)	1 (0.2)
Handicraft	0 (0.0)	8 (1.5)
Tailoring	0 (0.0)	3 (0.6)
Housemaid	0 (0.0)	2 (0.4)
Doing something else	2 (0.5)	0 (0.0)

*Asked to married women only

Access to information

Access to a mobile phone and internet: Figure 1 shows the proportion of respondents who reported having access to mobile phones and internet services in both survey rounds. It shows that mobile phone access was higher among the endline survey respondents (89.7%), compared to the baseline participants (72.4%). Similarly, internet access was higher among endline respondents compared to those at baseline.

Figure 1: Percent distribution of respondents by access to mobile phone and internet



Use of social media: Figure 2 presents the proportion of respondents who reported using any form of social media. Data indicate that 64.5% of respondents reported using social media at baseline, which was 72.2% at endline.

Figure 2: Percent distribution of respondents by use of social media

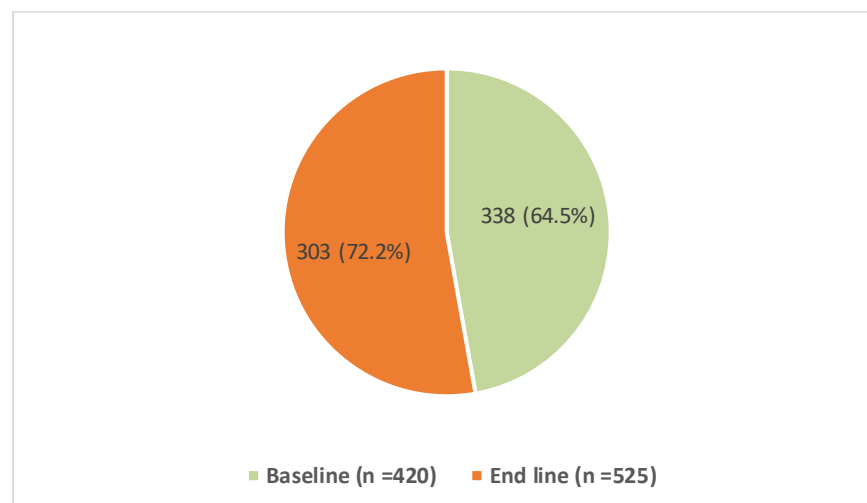


Table 2 shows the types of social media platforms used by respondents who had access to social media. Among respondents who used social media in the past week, YouTube, Facebook, and WhatsApp were the most commonly used platforms at both baseline and end-line. Notably, WhatsApp usage was considerably higher among endline respondents than among those at baseline.

Table 2: Type of social media account used in the past week

Social media*	Baseline (n = 149)	Endline (n = 379)
	n (%)	n (%)
YouTube	140 (94.0)	367 (96.8)
WhatsApp	46 (30.9)	296 (78.1)
Facebook	111 (74.5)	298 (78.6)
Instagram	10 (6.7)	38 (10.0)
None	2 (1.3)	0 (0.0)
TikTok, Imo, Likee	20 (13.4)	68 (17.9)

*Multiple responses considered

Findings for objective 1: Assess changes in knowledge and awareness among the women of reproductive age who have been reached by the project related to SRHR services, including family planning, menstrual hygiene, MR, PAC, and SGBV

Key findings

- Knowledge of family planning methods was nearly universal (>99%).
- MR/MRM awareness was high at both survey points — 87.9% at baseline and 84.6% at endline
- Knowledge of specific methods (e.g., implants) was higher at endline, though awareness of Intra-Uterine Devices (IUD) and sterilization was lower.
- A considerably higher percentage of respondents at endline identified outreach workers/community volunteers as a primary source of information on SRHR issues.
- Health-seeking behavior improved, with increased visits to government facilities (31.6% to 72.6%).

Access to general healthcare services

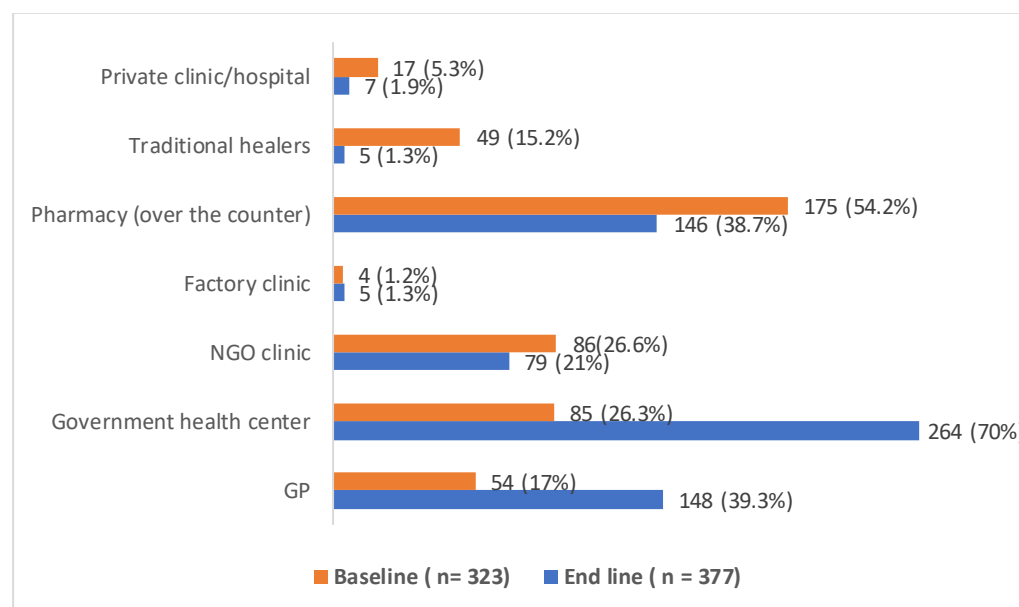
Table 3 presents the proportion of respondents who accessed general health care services in the year preceding each survey round. Data show that 76.9% of respondents reported accessing general healthcare services in the baseline survey, compared to 71.8% in the endline survey.

Table 3: Percentage of respondents accessing general health care services preceding the survey year

Survey round	n (%)
Baseline (n = 420)	323 (76.9)
Endline (n = 525)	377 (71.8)

Figure 3 presents the types of healthcare providers visited by respondents in the past year. At baseline, the most commonly reported providers were pharmacies (54.2%), followed by Non-Governmental Organization (NGO) clinics (26.6%) and government health centers (26.3%). At the end line, government health centers were the most frequently reported (70.0%), followed by general practitioners (39.3%) and pharmacies (38.7%).

Figure 3: Percent distribution of respondents by type of health care providers seen in the past year



SRH care-seeking behavior among ever-married women

The proportion of respondents who visited a health care provider for SRH services in the past year increased from 119 out of 388 respondents (30.7%) at baseline to 188 out of 475 respondents (39.6%) at end line. Table 4 indicates the types of health care providers consulted by married women and adolescents who have seen a health care provider for SRH services. Among respondents, NGO clinics were the most commonly visited provider at baseline (47.1%), while government health centres were the most frequently consulted at endline (68.1%). GP consultations were notably higher among end-in respondents than at baseline, as was pharmacy use. In contrast,

NGO clinic and outreach worker consultations were higher among baseline respondents compared to those at end-line.

Table 4: Type of health care providers consulted for SRH services

Response*	Baseline (n = 119)	Endline (n = 188)
	n (%)	n (%)
GP	21 (17.6)	98 (52.1)
Government health centres	27 (22.7)	128 (68.1)
NGO clinic	56 (47.1)	30 (16.0)
Factory clinic	1 (0.8)	1 (0.5)
Pharmacy (over the counter)	6 (5.0)	38 (20.2)
Traditional healers	6 (5.0)	3 (1.6)
Outreach worker/Volunteer	21 (17.6)	7 (3.7)
Other	3 (2.5)	2 (1.06)

**Multiple responses considered. Percentages may not add 100% due to multiple choices*

Table 5 presents the most common reasons for visiting healthcare providers for SRHR services. At baseline, the most common reason was visit from NGO workers for family planning (39.8%). At the endline, the most reported reasons included menstrual problems (31.9%) and learning about family planning (28.4%). Other reported reasons include pregnancy check-ups, family planning uptake, and lower abdominal pain.

Table 5: Reason for the visit

Reason *	Baseline (n = 119)	Endline (n = 188)
	n (%)	n (%)
To take Family planning Method	13 (11.5)	34 (18.1)
Genital tract infections	6 (5.3)	2 (1.0)
Infection in uterus	2 (1.8)	6 (3.2)
NGO workers visited for FP	45 (39.8)	0 (0.0)
Pregnancy test	9 (8.0)	0 (0.0)
Baby Delivery	5 (4.4)	(0.0)
Menstrual problem	16 (14.2)	60 (31.9)
Pregnancy check-up	5 (4.4)	20 (10.6)
General health check-up	5 (4.4)	0 (0.0)
MR	2 (1.8)	2 (1.0)
To learn about family planning	5 (4.4)	53 (28.39)
Anemia and weakness	0 (0.0)	4 (2.1)
	0 (0.0)	1 (0.5)

Reason *	Baseline (n = 119)	Endline (n = 188)
	n (%)	n (%)
To learn about sexually transmitted diseases	0 (0.0)	2 (1.0)
To fix problem at the implant insertion site	0 (0.0)	16 (8.5)
Lower abdominal pain		

**Multiple responses considered*

Performance Measurement Framework (PMF) indicator #1120: Knowledge and awareness of ever-married women and adolescents about family planning and MR-PAC

PMF indicator 1120.4 measures the number/proportion of women who perceive that they are aware of SRHR and SGBV issues, rights, and where and how to access services. This indicator is further disaggregated into: (i) women's perceived awareness of family planning, MR, and SGBV issues, and (ii) women's perceived awareness of where to access family planning and MR services. Regarding awareness of family planning, 39.0% of baseline respondents and 80.63% of endline respondents demonstrated knowledge of at least four modern family planning methods; the endline figure exceeds the project target of 60–70%. Awareness of MR was 88.0% at baseline and 84.6% at end-line, falling short of the project target of 90–100%.

Regarding awareness of where to access services, knowledge of family planning service locations was 89.0% at baseline and 99.8% at end-line, nearly meeting the project target of 100%. Awareness of where to access MR services was 70.7% at baseline and 97.5% at end-line, meeting the project target of 90–100%.

Table 6: Women's perceived awareness of the SRHR issues, rights, and where/how to access services

Indicator	Baseline (n = 383)	Endline (n = 475)	Project target (%)
	n (%)	n (%)	
Awareness of SRHR and SGBV issues (perceived)			
Awareness of family planning (knowledge of four modern family planning methods)	147 (39.0)	383 (80.63)	60-70%
Awareness of MR	341 (88.0)	444 (84.6)	90-100%
Awareness of where to access SRHR services (perceived)			
Awareness of where to access family planning services	341 (89.0)	474 (99.8)	100%

Awareness of where to access MR services	241 (70.7)	392 (97.5)	90-100%
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Awareness of family planning methods

Table 7 presents the types of family planning methods mentioned by the respondents who knew about family planning items. Among the family planning methods mentioned by respondents, (Depo Provera) injection, oral contraceptive pills, and condoms were the most commonly cited methods at both baseline and endline. Awareness of implants was higher among endline respondents (77.4%) compared to baseline respondents (62.9%), as was awareness of emergency contraceptives. In contrast, awareness of IUD and tubectomy/vasectomy was higher among baseline respondents than at endline. Notably, all endline respondents (100%) mentioned oral contraceptive pills, compared to 85.4% at baseline.

Table 7: Lists of family planning methods mentioned by the respondents

FP method*	Baseline (n = 383)	Endline (n = 474)
	n (%)	n (%)
Oral Contraceptive Pills	327 (85.4)	474 (100.0)
Condom	342 (89.3)	435 (91.8)
Injection (Depo Provera)	360 (94.0)	445 (93.9)
Emergency contraceptives	216 (56.4)	301 (63.5)
Implant	241 (62.9)	367 (77.4)
IUD	110 (28.7)	78 (16.5)
Tubectomy, Vasectomy	113 (29.5)	43 (9.1)
Don't want to answer	1 (0.3)	0 (0.0)

**Multiple responses considered*

Table 8 presents the sources from which respondents reported obtaining information on family planning. Family members/relatives and friends/neighbors were the most commonly cited sources among baseline respondents, whereas community volunteers were by far the most frequently reported source among endline respondents (88.2%), followed by doctors or nurses and pharmacies. Social media and hotline services were cited by a notably higher proportion of endline respondents compared to those at baseline.

Table 8: Sources of information on family planning

Response*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Family members/relatives	211 (55.1)	170 (35.8)
Friends/neighbor	163 (42.6)	18 (3.8)
Doctor or nurse (at a facility)	150 (39.2)	255 (53.7)
Pharmacy (over the counter)	128 (33.40)	206 (43.4)

Response*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Outreach workers/Volunteer	98 (25.6)	419 (88.2)
Social media	2 (0.5)	21 (4.4)
Teacher or school staff	1 (0.3)	1 (0.2)
Hotline service providers	1 (0.3)	100 (21.1)
Don't want to answer	1 (0.3)	0 (0.0)

**Multiple responses considered.*

Table 9 presents respondents' awareness of options available when menstruation is delayed and an unintended pregnancy is suspected. Buying a pregnancy test kit from a pharmacy was the most commonly cited option at both baseline and end-line, reported by 79.6% and 75.4% of respondents, respectively. Consulting a GP was cited by a higher proportion of endline respondents (30.1%) compared to those at baseline (18.8%), as was purchasing MRM drugs over the counter (51.6% at endline vs 17.0% at baseline).

Table 9: Options available when menstruation is delayed, and an unintended pregnancy is suspected

Response*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
There is nothing she can do	6 (1.5)	9 (1.9)
Buy pregnancy tests from a pharmacy	309 (79.6)	358 (75.4)
Buy MRM drug (over the counter)	66 (17.0)	245 (51.6)
Visit government health clinic	123 (31.6)	345 (72.6)
Consult with GP	73 (18.8)	143 (30.1)
Visit NGO clinic	94 (24.2)	56 (11.8)
Go to a traditional healer	18 (4.6)	35 (7.4)
Unsure	9 (2.3)	9 (1.9)
Don't want to answer	1 (0.3)	0 (0.0)

**Multiple responses considered*

Awareness of MR/MRM

Table 6 shows that 88.0% of respondents at baseline and 84.6% at endline were aware of MR/MRM. Those who knew about MR/MRM were further asked about the source of obtaining such information. Table 10 presents the sources from which respondents reported obtaining information on MR and PAC.

Family members/relatives and doctors or nurses were the most commonly cited sources among baseline respondents, whereas community volunteers were by far the

most frequently reported source among endline respondents (92.8%), followed by doctors or nurses and pharmacies. Notably, hotline services and social media were cited by a higher proportion of endline respondents as compared to friends/neighbors, who were more commonly reported as a source among baseline respondents.

Table 10: Sources of information on MR and PAC

Response*	Baseline (n = 388)	Endline (n = 402)
	n (%)	n (%)
Doctor or nurse (at a facility)	151 (44.3)	193 (48.0)
Pharmacy (over the counter)	100 (29.3)	152 (37.8)
Outreach worker/volunteer	53 (15.5)	373 (92.8)
Family members/relatives	165 (48.4)	130 (32.3)
Friends/neighbor	132 (38.7)	17 (4.2)
Hot line	0 (0.0)	95 (23.6)
Teacher	0 (0.0)	3 (0.3)
Social media	0 (0.0)	19 (4.7)
Don't want to answer	4 (1.2)	0 (0.0)

*Multiple responses considered

Findings for Objective 2: Assess any changes in attitudes and beliefs about early marriage and pregnancy, family planning, MR, PAC, and SGBV among the women of reproductive age who have been reached by the project

Key Findings • Positive attitudes toward family planning access remained high (>98% agreement). • Perception of MR as safe procedure was higher among endline respondents (35.2% to 79.1%). • Support for legal age of marriage (18+ for girls, 21+ for boys) was slightly higher at endline • Joint decision-making within couples was higher across all domains (having children, contraception, and MR). In summary, attitudes have shifted toward more informed, supportive, and gender-equitable perspectives

Attitudes towards family planning methods and MR

Table 11 presents respondents' perceptions regarding family planning services. The proportion of respondents who agreed that they know where to access family planning services increased from 89.0% at baseline to 99.8% at end line. Regarding the availability of family planning services in the community, 84.9% agreed at baseline compared to 84.4% at end line. For the statement that family planning services

should be easier to access, agreement was high at both survey points (94.5% vs 98.7%).

Table 11: Perception regarding family planning services

Perception	Opinion (Baseline n = 383, Endline n = 475)							
	Agree		Disagree		Neither agree nor disagree		Don't know	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
When needed, I know where to access family planning services (e.g., access to contraception)	341 (89.0)	474 (99.8)	21 (5.5)	0 (0.0)	5 (1.3)	0 (0.0)	16 (4.2)	1 (0.2)
Family planning services (e.g., access to contraception) are available to everyone in my community who needs them	325 (84.9)	401 (84.4)	14 (3.7)	49 (10.3)	14 (3.7)	21 (4.4)	30 (7.8)	4 (0.8)
I think family planning services (e.g., access to contraception) should be easier to access for more people in my community	362 (94.5)	469 (98.7)	1 (0.3)	5 (1.1)	8 (2.1)	0 (0.0)	12 (3.1)	1 (0.2)

NB: Values are written as n (%).

Table 12: Attitude towards the safety of MR

Statement	Opinion (Baseline n = 341, End line n = 402)							
	Agree		Neither agree nor disagree		Disagree		Don't know	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
I think MR is a safe procedure	120 (35.2)	318 (79.1)	18 (5.3)	10 (2.5)	178 (52.2)	20 (5.0)	25 (7.3)	54 (10.3)
When needed, I know where to access MR	241 (70.7)	392 (97.5)	7 (2.1)	3 (0.7)	33 (9.7)	5 (1.2)	60 (17.6)	2 (0.5)
I think MR should be easier to access to more people in my community	270 (79.2)	368 (91.5)	19 (5.6)	4 (1.0)	24 (7.0)	7 (1.7)	27 (7.9)	23 (5.7)

NB: Values are written as n (%).

Table 12 presents respondents' attitudes towards MR who have familiarity with MR/MRM. Regarding perceptions of MR as a safe procedure, 35.2% of baseline respondents agreed, compared to 79.1% of endline respondents. Knowledge of where to access MR services was higher among endline respondents (97.5%) compared to baseline (70.7%). Support for making MR more accessible within the community was reported by 79.2% of baseline and 91.5% of endline respondents, indicating broadly favorable attitudes toward MR access.

Table 13 presents the SRH topics that respondents expressed interest in learning more about. At baseline, detailed information on how each contraceptive method works and where to access it was the most commonly cited topic of interest (80.6%), followed by types of contraception (67.0%), how to end an unwanted pregnancy (72.4%), where to access MR (63.9%), and menstrual hygiene (58.5%). Similarly, at endline, detailed contraceptive information was the most frequently cited topic (80.0%), followed by how to end an unwanted pregnancy (71.6%), types of contraception (63.4%), where to access MR (47.6%), and menstrual hygiene (39.6%).

Table 13: Topics on SRH participants are interested in learning about

Response*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Type of contraception	260 (67.0)	301 (63.4)
Detailed information about how each method works, where to access contraception	313 (80.6)	380 (80.0)
Where to access MR	248 (63.9)	226 (47.6)
How to end an unwanted pregnancy	281 (72.4)	340 (71.6)
Menstrual hygiene	227 (58.5)	188 (39.6)
Other	10 (2.6)	0 (0.0)
Don't know/never thought about it	8 (2.1)	12 (2.5)
Don't need such information	11 (2.8)	5 (1.1)
Not eager to know	12 (3.1)	4 (0.8)
Don't want to answer	1 (0.3)	0 (0.0)

*Multiple responses considered.

Awareness about SGBV issues (ever-married women)

In this assessment, awareness of SGBV was only measured using questions on age of marriage. Tables 14 and 15 present respondents' views on the minimum appropriate age of marriage for girls and boys, respectively. Regarding girls, 90.5% of baseline respondents and 98.7% of endline respondents indicated that girls should marry at 18 or above. Regarding boys, 91.5% of baseline respondents and 93.7% of endline respondents indicated that boys should marry at 21 or above.

Table 14: The youngest age at which a girl should marry

Age	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
18 or above	351 (90.5)	469 (98.7)
Below 18	35 (9.0)	6 (1.3)
Don't know	2 (0.5)	0 (0.0)

Table 15: The youngest age at which a boy should marry

Age	Baseline (n =388)	Endline (n = 475)
	n (%)	n (%)
21 or above 21	355 (91.5)	445 (93.7)
Below 21	31 (8.0)	21 (4.4)
Don't want to answer	2 (0.5)	9 (1.9)

Table 16 presents respondents' views on who should hold decision-making authority regarding whether, when, and how many children to have. Joint decision-making by both husband and wife was the most commonly cited response at both baseline and end-line, reported by 75.8% and 94.9% of respondents, respectively. The husband alone was cited by 14.2% of baseline and 6.1% of endline respondents, while the wife alone was reported by 10.6% and 4.2%, respectively.

Table 16: Decision-making on whether, when, and how many children to have

Decision maker*	Baseline (n =388)	End line (n = 475)
	n (%)	n (%)
Husband	55 (14.2)	29 (6.1)
Wife	41 (10.6)	20 (4.2)
Couple (both husband and wife)	294 (75.8)	451 (94.9)
Mother	8 (2.1)	15 (3.2)
Mother-in-law	13 (3.4)	9 (1.9)
Other family members	4 (1.0)	5 (1.1)
Not sure	2 (0.5)	0 (0.0)

*Multiple responses considered

Table 17 presents respondents' views on who should hold decision-making authority on the use of contraceptive methods for limiting childbearing. Joint decision-making by both husband and wife was the most commonly cited response at both baseline and end-line, reported by 63.3% and 94.5% of respondents, respectively. The wife alone was cited by 18.6% of baseline and 4.6% of endline respondents, while the husband alone was reported by 16.2% and 5.3%, respectively. Healthcare providers were cited by a small proportion of respondents at both time points, along with other family members, including the mother and mother-in-law.

Table 17: Decision-making on the use of contraception to limit childbearing

Decision maker*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Husband	63 (16.2)	25 (5.3)
Wife	72 (18.6)	22 (4.6)
Couple (both husband and wife)	254 (63.3)	449 (94.5)

Decision maker*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Mother	2 (0.5)	18 (3.8)
Mother-in-law	1 (0.3)	6 (1.3)
Other family members	2 (0.5)	12 (2.5)
Health care provider	4 (1.0)	16 (3.4)
Not sure	3 (0.8)	1 (0.2)

*Multiple responses considered

Table 18 presents respondents' views on decision-making authority regarding MR/MRM. Joint decision-making by both husband and wife was the most commonly cited response at both baseline and endline, reported by 60.8% and 80.2% of respondents, respectively. The husband alone was cited by a notably higher proportion of baseline respondents (27.1%) compared to endline respondents (4.4%).

Table 18: Decision-making Authority regarding MR/MRM among women

Decision maker*	Baseline (n = 388)	Endline (n = 475)
	n (%)	n (%)
Husband	105 (27.1)	21 (4.4)
Wife	41 (10.6)	23 (4.8)
Couple (both husband and wife)	236 (60.8)	381 (80.2)
Mother	10 (2.6)	25 (5.3)
Mother-in-law	5 (1.3)	6 (1.3)
Other family members	3 (0.8)	11 (2.3)
Health care provider	5 (1.3)	39 (8.2)
Not sure	7 (1.8)	60 (12.6)
Don't want to answer	1 (0.3)	0 (0.0)

*Multiple responses considered

Findings for objective 3: Explore changes in the enablers and barriers in accessing and utilizing SRHR information and quality SRHR services among women of reproductive age and adolescent girls who have been reached by the project

Key Findings

- The majority reported no barriers to accessing SRHR services.
- Perceived ease of access improved across all indicators (transport, timing, independence).
- The ability to attend health services independently was higher in the endline
- Reliance on traditional healers was lower.

In summary, structural and perceived barriers were substantially lower at the endline, with a higher level of autonomy and access.

Table 19 presents the reasons reported by respondents for not accessing general health care services. Not needing services was the most commonly cited reason at both baseline and endline, reported by 78.4% and 96.6% of respondents, respectively. Expenses were cited by 14.4% of baseline and 7.4% of endline respondents, while lack of time was reported by 11.3% and 3.4%, respectively. Other barriers, such as queues at the health facility, transportation problems, and service unavailability, were cited by small proportions of respondents at both time points.

Table 19: Reason for not accessing general health care services

Response*	Baseline (n = 97)	Endline (n = 148)
	n (%)	n (%)
Did not need	76 (78.4)	143 (96.6)
Did not have time	11 (11.3)	5 (3.4)
Queue at the health facility	3 (3.1)	7 (4.7)
Did not know where to go	1 (1.0)	0 (0.0)
Expenses	14 (14.4)	11 (7.4)
Social acceptance (shame, prefer traditional medicine)	2 (2.1)	1 (0.7)
Not interested	2 (2.1)	0 (0.0)
Transportation problem	0 (0.0)	1 (0.7)
Service was not available	0 (0.0)	1 (0.7)
Timing of the health facility	0 (0.0)	1 (0.7)
Don't want to answer	1 (1.0)	0 (0.0)

*Multiple responses considered

Table 20 presents the time required to access the nearest health centre using different modes of transportation. At baseline, a large proportion of respondents reported reaching facilities within 0–5 minutes by walking (38.5%), whereas at endline, a higher proportion reported longer walking times, including 22.3% reporting more than one hour. For rickshaw/Compressed Natural Gas (CNG) transport, the most common category at the endline was 5–10 minutes (49.0%), followed by 26–30 minutes (15.8%). Use of public transport showed that 61.7% reached within 0–10 minutes at the endline. Travel times by ambulance or car were mostly within 21–60 minutes (75.2%) at the endline.

Table 20: Time required to access the nearest health centre to see a doctor or a nurse by different modes of transportation

Response	Baseline (n = 420)	Endline (n = 525)
	n (%)	n (%)
By walking		
0-5 min	165 (38.5)	45 (8.6)
6-10 min	75 (17.4)	104 (19.8)

Response	Baseline (n = 420)	Endline (n = 525)
	n (%)	n (%)
11-15 min	13 (2.9)	53 (10.1)
16-20 min	30 (7.0)	43 (8.2)
21-25 min	1 (0.2)	10 (1.9)
25-30 min	39 (9.1)	42 (8.0)
31-40 min	2 (0.4)	16 (3.0)
45 min	1 (0.2)	18 (3.4)
46 min-1 hour	7 (1.6)	77 (14.7)
More than 1 hour	0 (0.0)	177 (22.3)
By ambulance or car		
≤20 min	1 (0.2)	395 (75.2)
21-60 min	0 (0.0)	118 (22.5)
1-1.5 hours	7 (1.6)	3 (0.8)
More than 1.5 hours	0 (0.0)	8 (1.5)
By Rickshaw or CNG or electric auto rickshaw		
5-10 min	34 (7.7)	257 (49.0)
11-15 min	21 (4.9)	22 (4.2)
16-20 min	20 (4.7)	31 (5.9)
21-25 min	4 (0.8)	16 (3.0)
26-30 min	20 (4.6)	83 (15.8)
31-40 min	8 (1.8)	61 (11.6)
More than 40 min	22 (6.2)	55 (10.5)
By public transport		
0-10 min	8 (2.0)	324 (61.7)
11-15 min	1 (0.2)	39 (7.4)
16-20 min	0 (0.0)	50 (9.5)
21-25 min	4 (1.0)	20 (3.8)
26-30 min	1 (0.2)	33 (6.3)
31-60 min	0 (0.0)	44 (8.4)
60 min or more	1 (0.2)	15 (2.9)

Table 21 presents respondents' agreement or disagreement regarding access to health services. The majority of respondents at both baseline and endline agreed that clinics were accessible by walking or public transport, and that clinic opening times were convenient, with agreement being higher among endline respondents for both statements. Agreement that respondents could attend a health visit on their own was reported by 57.9% of baseline and 93.5% of endline respondents — a notably high proportion at endline.

Table 22 presents the reasons reported by respondents for not accessing SRH services. Not needing services was the most commonly cited reason at both baseline and endline, reported by 88.8% and 97.5% of respondents, respectively. Among those who did report barriers, lack of time and expenses were the most frequently cited at

baseline, while queue at the health facility and expenses were among the reasons noted at endline.

Table 21: Reasons for not accessing SRH services

Reasons*	Baseline (n = 267)	Endline (n = 287)
	n (%)	n (%)
Did not need	237 (88.8)	280 (97.5)
Did not have time	31 (10.7)	9 (3.1)
Queue at the health facility	5 (1.7)	9 (3.1)
Did not know where to go	4 (1.4)	0 (0.0)
Service was not available	1 (0.3)	0 (0.0)
Expenses	7 (2.4)	7 (2.4)
Transportation	1 (0.3)	1 (0.3)
Social acceptance	2 (0.7)	0 (0.0)
Family barrier	1 (0.3)	0 (0.0)
Timing of clinic	0 (0.0)	1 (0.3)

**Multiple responses considered*

Table 22: Participant's agreement or disagreement relating to access to health services

Statement	Opinion (Baseline n = 420, End line n = 525)							
	Agree		Neither agree nor disagree		Disagree		Don't know/Not applicable	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Easily walk, or take a rickshaw, CNG or public transport to go to the clinic	352 (83.8)	493 (93.9)	36 (8.6)	6 (1.1)	26 (6.2)	26 (5.0)	6 (1.4)	0 (0.0)
The clinic is open at a time that is convenient for me	365 (86.9)	512 (97.5)	30 (7.1)	6 (1.1)	20 (4.8)	7 (1.3)	5 (1.2)	0 (0.0)
I can take time off from my work to go to a clinic (working women only)	129 (30.7)	394 (75.0)	31 (7.4)	15 (2.9)	28 (6.7)	42 (8.0)	2 (0.5)	74 (14.1)
I can attend a health visit on my own	243 (57.9)	491 (93.5)	148 (35.2)	1 (0.2)	25 (6.0)	33 (6.3)	4 (1.0)	0 (0.0)

NB: Values are written as n (%)

Table 23: Satisfaction level regarding SRH services

Response	Satisfaction level (Baseline n = 268, End line n = 188)					
	Very good/good		Average		Poor/very poor	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Being friendly and giving emotional support	199 (74.2)	169 (89.9)	52 (19.4)	19 (3.6)	17 (6.34)	0 (0.0)
Taking the time to find out what your concerns are	189 (70.5)	31 (16.5)	57 (21.2)	126 (67.4)	23 (8.58)	30
Considering your preferences in making decisions about your health and treatment	188 (70.1)	156 (82.9)	56 (20.9)	32 (6.1)	25 (9.3)	0 (0.0)
Using plain and easy to understand language	216 (80.6)	157 (83.5)	49 (18.3)	31 (5.9)	4 (1.5)	0 (0.0)
Giving understandable answers in response to your questions	213 (79.5)	157 (83.5)	44 (16.4)	31 (16.5)	12 (4.5)	0 (0.0)

NB: Values are written as n (%)

Table 23 presents respondents' satisfaction levels with healthcare provider interactions. This analysis was done after excluding the don't know/don't want to answer option. Across most dimensions, the majority of respondents at both baseline and endline rated their experience as very good or good, with endline respondents reporting higher satisfaction for most aspects, including friendliness and emotional support (74.2% at baseline and 89.9% at endline), consideration of preferences in decision-making, and use of plain language.

Findings for objective 4: Assess the appropriateness of the project's community-based events—including content, delivery methods, timing, location, inclusiveness, safety/comfort, and facilitation

The endline assessment objective 4 focused on the effectiveness of project-supported community events. This objective was not relevant at baseline and was therefore not included in the baseline assessment.

Key findings

- Most respondents found the events useful (88.0%) and the content easy to understand (88.4%).
- Satisfaction with timing, location, and setting was high (88.4%).
- The main barrier to understanding was environmental distraction, e.g.; noise, crowd (63.2% among those reporting difficulty).

In summary, community events were well-received, relevant, and acceptable to participants.

Table 25 presents endline respondents' perceived usefulness of the community event content. The large majority of respondents (88.0%) found the community event content useful.

Table 24: Perceived usefulness of the community event content (n = 525)

Response	n (%)
Yes	462 (88.0)
No	30 (5.7)
Not sure	27 (5.1)
Don't remember	6 (1.1)

Table 26 presents endline respondents' perceived ease of understanding the community event content. The large majority of respondents (88.4%) found the content easy to understand.

Table 25: Perceived ease of understanding of the event content (n = 525)

Response	n (%)
Yes	464 (88.4)
No	24 (4.6)
Not sure	28 (5.3)
Don't remember	9 (1.7)

Table 27 presents the reasons reported by respondents who found the community event content difficult to understand (n = 52). The most commonly cited reason was too many distractions or an unfavorable environment (63.2%), followed by the topic being difficult (32.7%).

Table 26: Reasons for difficulty in understanding the content (n = 52)

Response	n (%)
The topic was difficult	17 (32.7)
The facilitators were not sound	7 (13.5)
There were too many distractions/obstacles (unfavorable environment)	43 (63.2)

Table 28 presents endline respondents' assessment of the timing, location, and environment of the community events. The large majority of respondents (88.4%) rated the timing, location, and environment as satisfactory.

Table 27: Assessment of the timing, location, and environment (safety and comfort) of the event (n = 525)

Response	n (%)
Yes	464 (88.4)
No	41 (7.8)
Not sure	16 (3.0)
Don't remember	4 (0.8)

Table 29 presents suggestions from endline respondents for improving the timing, location, and environment of community events. The majority of respondents had no specific suggestions. Among those who did, the feedback clustered around three broad themes:

- Improving the physical environment and logistics (such as ensuring a comfortable environment, using a larger venue, and informing participants in advance);

- Enhancing event structure and engagement (such as longer meeting times, regular discussions, and separate Q&A sessions);
- Broadening participation (such as organizing sessions by age group and inviting male participants).

Table 28: Suggestions for Improving the Timing, Location, and Environment of the Event

Response	n (%)
It would have been better if the meeting time had been longer	51 (9.7)
Separate time slots can be allocated for Q/A session	1 (0.2)
Regular discussion	32 (6.1)
Fewer participants should be invited	5 (0.9)
A large venue would be better	43 (8.2)
Ensure a comfortable environment	61 (11.6)
Need more detailed info on contraceptive	2 (0.4)
Inform before the meeting	14 (2.7)
Leaflet	3 (0.6)
Males should also be invited	1 (0.4)
Organize the discussion separately based on age groups	12 (2.3)
Organize events on weekend days	4 (0.7)
No comment	322 (61.3)

Findings for objective 5: Explore participants' perceived learning and key takeaways from the events, including what was new, most helpful, or most memorable

This objective focused only on direct project participants who participated in at least one community event. Hence, this section covers only the endline survey participants.

Key findings

- Nearly half (49.7%) reported learning about family planning and unwanted pregnancy.
- Other key learning areas included menstrual hygiene (15.2%) and pregnancy care (13.5%).

- Awareness increased for almost all respondents (99% reported some level of increase).

In summary, community sessions contributed to broad-based SRHR learning across multiple topics.

Table 30 presents knowledge gained on SRHR from the community events, as reported by endline respondents through an open-ended question. The most commonly cited areas of knowledge gained were menstrual hygiene management, family planning and unwanted pregnancy prevention, and female SRH and pregnancy care. Other frequently mentioned topics included learning where to access SRH services, the effects of early marriage and physical and mental changes during adolescence, and women's rights and health.

Table 29: Knowledge gained on SRHR from the event (n = 525)

Response	n (%)
Family planning and unwanted pregnancy	261 (49.7)
Gained understanding of safe and adolescent-friendly health care services	9 (1.7)
Learned where to access health care services related to SRH	44 (9.4)
Irregular menstruation management	15 (2.8)
Learned about the gaps between 2 children	7 (1.3)
Both males and females should be familiar with family planning items	6 (1.1)
Women's rights, women's health, and access to health care services	28 (5.3)
Take regular health services	8 (1.5)
SRH issues should be discussed with family members	15 (2.8)
Female SRH, pregnancy care	71 (13.5)
Free call service to OGSB	10 (1.9)
How to maintain hygiene during menstruation	80 (15.2)
Learned about STI	12 (2.3)
Early marriage effect and physical and mental changes during adolescence	38 (7.2)
No response/Can't remember	32 (6.1)

Table 31 presents end-point respondents' perceptions of the impact of community events on SRHR awareness among themselves and their communities. The large

majority of respondents reported a positive impact, with 99% % indicating that awareness increased.

Table 30: Perceived impact of the event on SRHR awareness among respondents and their communities (n = 525)

Response	n (%)
The awareness level increased	520 (99.0)
No change	5 (1.0)

Findings for objective 6: Understand whether the information from the events influenced participants' ability to seek SRH information or support/services

This objective focused only on direct project participants who participated in at least one community event. Hence, this section covers only the endline survey participants.

Key Findings

- A large majority (83.2%) reported that the events helped them access SRH information or services.
- Key pathways included:
 - Ability to advise others (21.3%)
 - Knowledge of family planning (17.1%)
 - Awareness of SRHR rights and services (6–7%)
- Improvements also included communication skills and service navigation.

The intervention translated knowledge into practical service-seeking behavior and peer influence.

Table 32 presents endline respondents' views on whether the knowledge acquired from community events had an effect on access to SRH information and services among themselves and their peers. The large majority of respondents (83.2%) reported a positive effect.

Table 31: Effect of acquired knowledge on access to SRH information and services among respondents and their peers (n = 525)

Response	n (%)
Yes	437 (83.2)
No	4 (0.8)
Not sure	84 (16.0)

Table 33 presents the specific ways in which community discussion events impacted respondents' access to SRH information and services, as reported through an open-ended question. The most commonly cited impact was being able to advise others (21.3%), followed by increased knowledge of family planning methods (17.1%).

Other frequently mentioned impacts included increased awareness of sexual violence, abortion, and related health risks, knowledge of SRH rights and health, and the ability to access SRH services.

Table 32: Impact of community discussion events on respondents' access to SRH information and services

Response	n (%)
Know about the hotline number	39 (7.4)
Know how to manage irregular menstruation	18 (3.4)
Can access SRH services	34 (6.5)
Know about sexual and reproductive right and health	36 (6.8)
Aware of the equal rights of males and female	5 (0.9)
Increased awareness of sexual violence, abortion, and related health risks	35 (6.7)
Can discuss with husband and family members about family planning	7 (1.3)
Being able to speak openly with doctors about the SRH issue	3 (0.56)
Know about family planning methods	90 (17.1)
Relief from abdominal pain	4 (0.7)
Learned how to maintain hygiene during menstruation	10 (1.9)
Learned about Sexually Transmitted Infections (STIs) and early marriage	17 (3.2)
I can advise others	112 (21.3)
learned strategies for mental health and stress management	5 (0.9)
No comment	130 (24.7)

Discussion and Recommendations

The endline assessment indicates high levels of SRHR awareness, perceived access to SRH services, and gender-equitable attitudes among women and adolescent girls reached through the ISRHRD project. As part of the intervention, the project implemented several community-based activities that likely contributed to improved SRHR awareness and care-seeking behaviour in underserved urban areas. At the community level, extensive outreach activities were carried out through a network of 1,000 volunteers and 100 community action groups, helping to create an enabling environment for women, adolescents, and marginalized populations.

The findings indicate a higher level of awareness of modern family planning methods at end-line, notably surpassing the project's target. The project implemented a wide range of initiatives, including stakeholder meetings, GP–volunteer networking sessions, community health camps, school-based activities, and volunteer-led awareness campaigns, as well as the observance of key SRHR-related days such as World Population Day, Safe Motherhood Day, and World Contraception Day across DNCC and DSCC. Furthermore, the project strengthened the capacity of outreach workers from UPHCSDP clinics through training and supportive supervision, enabling them to effectively facilitate regular courtyard sessions in the community. These interventions appear to have contributed to increased SRHR awareness and improved access to services.

Awareness of MR, while already relatively high at baseline, saw a marginal decline at endline and fell short of the project target. It is possible that the relatively high baseline figure left limited room for demonstrable gain, or that MR-specific messaging was less consistently reinforced compared to broader family planning communication. Another reason could be social desirability bias. MR is still a sensitive topic in the context of Bangladesh, and at endline, respondents may have been more cautious or reluctant to acknowledge awareness due to stigma, fear of judgment, or perceived legal/religious concerns.

A noticeable increase was observed in the proportion of endline respondents who reported volunteers and outreach workers as important sources of information on family planning, MR, and PAC. There was also a considerable increase in the proportion of respondents identifying doctors, pharmacies, hotlines, and social media as important sources of information for these SRH issues. These changes may partly reflect the project's continuous engagement with more than 100 GPs, a network of 1,000 volunteers, and 100 Community Action Groups throughout the intervention period. In addition, the project directly engaged pharmacies by providing pharmacy workers with orientation and training on FP, MR, and PAC services. Participating pharmacies were also rebranded with greater visibility through the project's "Women's Plus" logo, identifying pharmacies that provide FP, MR, and PAC-related services. The project also maintained a Facebook page with more than 39,000 followers, regularly sharing information and awareness messages related to MR, PAC, FP, and GBV through boosted posts that reached large numbers of community members. The project volunteers also frequently have communicated to the community about the availability and number of a project supported OGSB call centre whereby community can access information and services on SRH which likely explains hotlines as an important source of information of SRH.

Government health centres and GPs emerged as the most frequently utilized healthcare service points for SRH services. The project worked closely with more than 100 GPs through training, equipping, and ongoing mentorship to initiate or strengthen the provision of SRH services, which likely contributed to increased utilization of GP services. Similarly, the project supported government health centres, particularly referral hospitals, through training, supportive supervision and provision of essential equipment, which may partly explain their high levels of use.

However, comparison between baseline and endline findings shows a decline in visits to UPHCSDP clinics. This may reflect a shift in care-seeking preferences, with some

individuals now choosing GPs as the most convenient option, while others may bypass primary-level clinics and seek care directly from referral centres offering more advanced services. It is also important to note that prior to project implementation, GPs were not providing MR, PAC, FP, and SGBV services. With project support, these services became available through GPs, which may have contributed to a shift in service utilization from UPHCSDP clinics to GPs located closer to communities. This suggests improved availability and accessibility of services within community settings. However, the shift in care-seeking behaviour highlights the need for further qualitative exploration to better understand the drivers of this shift. It should also be noted that the baseline and endline surveys were conducted with different cohorts, which may partly account for observed differences.

The findings also reveal a meaningful shift in respondents' awareness of available resources when menstruation is delayed, and an unintended pregnancy is suspected. Purchasing a pregnancy test kit from a pharmacy remained the most frequently cited option at both baseline and endline. This likely reflects the broader context in Bangladesh, where MRM drugs and pregnancy kits are widely accessible (11). Buying these drugs/kits directly from local pharmacies seems to be a common practice, especially in urban areas. This pattern was observed in both the baseline and endline findings.

The change in attitudes toward MR from baseline to endline is one of the most important findings of this study. There was a large increase in the number of people who see MR as a safe procedure. This shows not only better awareness but also a bigger change in community attitudes. Thus, it is reasonable to suggest that the project played a role, given its wide and consistent community engagement activities. This suggests that the project was effective not only in sharing information but also in creating a more supportive environment around MR.

The findings on decision-making process over childbearing and contraception use reveal a similarly encouraging trend. A marked shift toward joint husband-wife decision-making was observed across all three domains — decisions about whether and when to have children, contraceptive use, and MR. Notably, the proportion of respondents attributing sole decision-making authority to the husband declined considerably, particularly in relation to MR decisions. This suggests that the project's community-level interventions may have contributed to a gradual rebalancing of household decision-making dynamics around reproductive health.

One encouraging finding of the study was that a large majority of women (93.4%) reported being able to attend a health visit on their own, representing a substantial increase from the baseline (57.9%). This finding may indicate improved autonomy among women in making decisions related to their SRH needs. Several factors may have contributed to this change, including increased awareness generated through community awareness sessions. Through these sessions, community volunteers not only provided education on topics such as family planning, MR/PAC, and SGBV, but also shared practical information on where and how to access these services. Increased awareness of available services and access points may have further empowered women to seek care independently.

The findings on the quality and impact of community events suggest that the project's activities were well-received, relevant, and effective. Participants reported learning about a wide range of SRHR topics, with family planning, prevention of unwanted pregnancy, menstrual hygiene, and pregnancy care most commonly mentioned as key areas of knowledge gained. Most participants also mentioned the community sessions improved SRHR awareness not only for themselves but also within their wider communities. This suggests a wider ripple effect, as many participants reported that they were able to advise others based on what they learned. The pedagogical approach was perceived as generally sound. However, improving the physical setting, such as ensuring enough space and limiting group size (participants' number in each session), could make future sessions even more effective.

The SRH topics that respondents wanted to learn more about show a similar pattern at both baseline and endline. This reflects community's wide ongoing need for information. It is also possible that some participants did not attend all community sessions, which may have left gaps in their knowledge of certain topics. The continued interest in these topics, even after exposures, shows that SRHR education at the community level is not a one-time need, but should be an ongoing process.

Limitations

Cross-sectional design: The endline and baseline surveys were two independent cross-sectional surveys, and therefore, the observed differences cannot be attributed to the project intervention. There is a difference between the two survey participants.

No qualitative triangulation: The absence of Focus Group Discussions/Key Informant Interviews limits depth of understanding about why attitudes changed and how social norms shifted; qualitative data would clarify the pathways of change.

Cultural sensitivity constraints: Restrictions on asking unmarried women about SRHR have constrained access to such information among unmarried women. Furthermore, family planning and MR are culturally sensitive topics in the context of Bangladesh; some respondents were not comfortable discussing SRHR issues. To overcome this limitation, the field enumerators built a rapport with them to make them comfortable.

Conclusion

The endline assessment suggests that the ISRHRD project made important contributions toward improving SRHR awareness, perceived access to services, and gender-equitable attitudes among women and adolescent girls in underserved urban communities of Dhaka. Through a combination of community outreach, volunteer engagement, capacity strengthening of healthcare providers, pharmacy engagement, and social media awareness activities, the project appears to have created a more supportive environment for accessing SRHR information and services.

The findings indicate notable improvements in awareness of family planning methods, positive attitudes toward MR, women's autonomy in seeking healthcare, and joint decision-making within households regarding reproductive health matters.

Increased recognition of volunteers, outreach workers, pharmacies, hotlines, and social media as important sources of SRHR information further highlights the project's success in strengthening community-based information networks. The increased utilization of GP services also suggests that expanding SRHR services closer to communities can improve accessibility and convenience for service users.

At the same time, the findings demonstrate that continued efforts are needed to sustain and deepen progress. Persistent demand for SRHR information, limited improvement in MR awareness, and shifts in care-seeking patterns underscore the importance of ongoing community engagement, strengthened referral pathways, and further exploration of barriers and preferences influencing service utilization. Future interventions should continue investing in community-based education, provider capacity strengthening, and gender-transformative approaches while ensuring that marginalized populations remain at the centre of programming. Overall, the findings suggest that integrated, community-oriented SRHR interventions can play a meaningful role in improving awareness, autonomy, and access to SRHR services in urban Bangladesh.

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Annex 1: Data collection team and training schedule

Data collection team

Name	Education	Role
Team A		
Bijoya Saha	MSS (with thesis) in Sociology, Shahjalal University of Science and Technology	Supervisor
Foujia Afroz	M.S.S in Political Science, University of Dhaka	Enumerator
Moni Akter	M.A in Sociology, National University	Enumerator
Anuka Saha	M.A in Islamic studies, National University	Enumerator
Team B		
Kakoly Anny Mary Das	BSS in Sociology, Bangladesh University	Supervisor
Afroza Khatun	B.A (pass), National University	Enumerator
Aparna Dey	M.A in Sociology, National University	Enumerator
Jhinuk	M.A in Sociology, National University	Enumerator

Training schedule

Day 1 (Date: 4 March, 2026)

Time	Activities	Facilitator
9:00 AM- 9:30 AM	Arrival and signing	BISR Team
9:31 AM- 9:45 AM	Introduction of facilitators and participants	BISR Team
9:46 AM- 11:45 PM	Overview of the ISRHRD project followed by Q/A	Ipas Team
11:46 PM- 12:00 PM	Short break	BISR Team
12:01 PM-12:30 PM	General Discussion on SRHR issue	BISR Team
12:31 PM- 1:30 PM	Discussion on Questionnaire Followed by Q/A	BISR Team
1:31 PM-2:00 PM	Prayer break	-
2:01 PM – 3:00 PM	Discussion on Questionnaire Followed by Q/A	BISR Team
3:01 PM- 3:30 PM	Open Discussion	-
3:31 PM- 3:45 PM	Closing	BISR Team

Day 2 (Date: 5 March, 2026)

Time	Activities	Facilitator
9:30 AM- 10:45 AM	Ethics training	BISR Team
10:46 AM-11:45 AM	Questionnaire recap session followed by a quiz	BISR Team
11:46 AM- 12:00 PM	Short break	BISR Team
12:01 PM-1:15 PM	Practice session (Role play)	-
1:16 PM- 1:45 PM	Prayer break	BISR Team
1:46 PM- 2:30 PM	Feedback session	BISR Team
2:31 PM – 3:00 PM	Team distribution and briefing on field practice	BISR Team
3:01 PM- 3:30 PM	Closing	BISR Team