




BASELINE STUDY REPORT

VIOLENCE PREVENTION & RESPONSE PROJECT



 International Federation
of Red Cross and Red Crescent Societies



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Table of Content

Acknowledgement	04
Acronyms	05
Abstract	06
Chapter 1: Introduction	07
1.1 Introduction	09
Chapter 2: Methodology	11
2.1 Initial Planning for Baseline Study	14
2.2 Review of Literature	14
2.3 Feedback on Gender based Research:	14
2.4 Determination of Research methodology	14
2.5 Quantitative Techniques	14
2.5.1 Selection of Study Area	15
2.5.2 Respondent Selection	16
2.5.3 Sampling	16
2.5.4 Development and Review of Research tool	16
2.5.5 Training of Data Collection Team	16
2.5.6 Data reviewing, cleaning and processing	17
2.5.7 Data Entry and Analyses	17
2.6 Draft Report Preparations:	17
2.7 Final Report Preparation:	17
2.8 Limitations of this Study	17
Chapter 3: Study Findings	19
Chapter 4: Conclusion and Recommendation	43
4.1 Conclusion	45
4.2 Recommendations	46
References	47
Annex 1 Questionnaire	48
Annex 2 Project Profile	55
Annex 3 Photo Archive	57

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Acronyms

ANC	Antenatal Care
BCC	Behavior Change Communication
BDRCS	Bangladesh red Crescent Societies
CMW	Community Midwives
CHP	Community Health Promoters
GBV	Gender-based Violence
IEC	Information, Education and Communication
IFRC	International federation of Red Cross and Red Crescent Societies
ISBN	International Standard Book Number
MCH	Mother and Child Health Center
PSS	Psychosocial Support
RCRC	Red Cross and Red Crescent
SD	Standard Deviation
SDG	Sustainable Development Goals
SGBV	Sexual and Gender based Violence
UP	Union Parisad
VP&R	Violence Prevention and Response
WHO	World Health Organization

Abstract

Gender based Violence is a very common phenomenon in urban and rural communities in Bangladesh and the frequency of occurrence is very high during and after disaster situation. The epidemiological spread of violence is not something to be taken lightly as the consequences of violence in many cases are death, and it impacts the life and livelihood of girls and women. It is acknowledged that without addressing gender-based violence, the sustainable development goal (SDG 5) of Gender equality and empowering all women and girls cannot be achieved. Considering the magnitude of GBV in Bangladesh, Bangladesh Red Crescent Society Health department conducted a baseline study under its Violence prevention and Response Project (VP&R) Pilot Phase II to understand the magnitude of GBV in the selected project areas. This baseline study findings are driven applying both qualitative and quantitative research techniques. Quantitative data was collected through face to face interview using a predesigned structured questionnaire. Purposive sampling method was chosen for selecting the respondents considering the availability of female participation, evidence of higher violence among women. Whereas qualitative information was obtained through exploring case studies and focus group discussion (FGD). Whole research process has gone through an intense scrutiny process of reviewing existing secondary information, studying similar research findings in RCRC context, research tool preparation, data quality control etc. Descriptive analysis was done for data analysis and the findings were finally reported using necessary tabular and graphical presentation. The result shows that majority of the respondents were a sufferer of violence in their life either directly or indirectly. It was evidenced that 92.1% respondents got married below 18 years with an average marriage age of 15 years (mean 15.04 ± 2.052), as well as average age of first pregnancy at 16 years (mean 16.72 ± 2.044). Around 60% mentioned of having no health facilities near their living place during their pregnancy time and other health necessity. Also, 76% found not being able to get antenatal care (ANC), 82% did not get proper nutrition, 78.7% mentioned about not getting any physical and mental support from family during pregnancy in last one year, where 75% mentioned of facing violence because of giving birth to girl child. Majority of the decision makers at the household level was male (more than 80%). The study finding also revealed that majority of the respondents (70%) faced violence at least once or more at her lifetime, and most of the cases this violence is caused either by husband (53%) or by any family member (43%). The main reason of violence was family related matters and others were dowry, drug addiction, social insecurity etc. The consequences were end of education, work, suicide, physical injury, unwanted pregnancy etc. In 38.9% cases it affects by ending education of the respondent, end of work in 13.3% cases and rest were various kind of physical and mental health hazards (46%). Only 39% respondents who suffered violence sought for help. Only 24% got the help that they sought for. Eighty six percent of the respondents believes that giving dowry from bride's family is an important part of marriage. Very few respondents (15%) knows about the hotline number provided by Bangladesh Govt. to respond against gender-based violence. Finally, 91% respondents expressed that they want to seek help in case of any violence happens in their life. Qualitative data also reported that the current gender-based violence is happening due to poverty, dowry, child marriage, lack of education, lack of awareness on GBV etc. The study concludes that Gender Based Violence is yet a neglected subject where it should be one of the major areas to have an intense focus. To reduce the extent of gender-based violence, necessary measures like raising awareness of GBV for family and community, educating girls and women, reducing poverty, eradicating dowry and child marriage, strengthening the action of village court, creating employment opportunities for girls and women, establishing effective preventive, referral and response mechanism etc. should be taken immediately .

CHAPTER 1

INTRODUCTION

1.1 Introduction

Gender equality and empowering all women and girls is one of the 17 key global goals for sustainable development (SDG) for the world. It is also acknowledged that without addressing gender-based violence, this goal cannot be achieved; also, it places other SDG outcomes (such as leadership and livelihoods access for women and marginalized people) at risk. Thence, elimination of violence against women and addressing the root causes of violence are targets adopted by countries all over the world. One in three women faces physical or sexual violence during her lifetime, and after disasters the risk goes up because of a breakdown in essential services, increased poverty, poor emergency shelter design and inadequate coordination by disaster responders.

Bangladesh has a high prevalence of violence against women and girls as statistics shows. Almost two thirds (72.6%) of ever married women experienced one or more such forms of violence at least once in their lifetime.

There was a self-reported incident of sexual violence in a cyclone shelter from south-eastern region of Bangladesh in July 2012. A finding from community-based end line survey in July 2015 also showed that more than a quarter of women and men respondents expressed concern about privacy and safety of their daughters and daughters-in-laws.

Keeping all these in concern, BDRCS Health department piloted a project during FY 17/18 in 2 MCH centres - Horinagar MCH center of Satkhira district and Kazlakati MCH center of Barisal district. The project is named "Violence Prevention and Response (VP & R)".

Supported by Australian Red Cross (ARC), the pilot project assigned tasks like partner mapping, materials review workshop, revise/draft VP&R materials, sensitization workshop on VP&R for BDRCS staffs, handing over 7 lessons cards and training manual in Bangla.

During pilot project (I) period, a total of 25 Volunteers (CMWs, ACMWs, CHPs &RCYs) received TOT and 49 Community Volunteers received basic training on Violence Prevention & Response VP&R. Also, Awareness raised on VP&R to 6000 head of family members of those two MCH centres (Kazlakati & Horinagar). Then, BDRCS health department planned to implement the second phase in 2018/19.

The pilot phase (II) of Violence Prevention and Response (VP & R) is running by BDRCS Health Department in collaboration with International Federation of Red Cross and Red Crescent Societies with the funding support from Australian Red Cross. The pilot (II) project period was from June 2018 to June 2019 with the goal – "Increased safety and well-being of women, men, girls and boys in 5 districts of Bangladesh".

This project was being implemented in 5 MCH centres where 4 are based in coastal regions and one is in urban area. As planned, 15,000 Households (3000 around each MCH centre) including Mother, Neonatal, Child and Adolescent 82,500 people (5.5 per family times 15,000) are the direct beneficiaries of this project. Also, local leaders, schools, social institutions will be involved to raise awareness against Violence prevention and response among people.

Under the pilot phase II, an induction workshop and a theory of change workshop were conducted; the project staffs receive TOT for conducting VP & R Sessions at community/Household Visit. workshops on VPR for UP were held at project areas, and IEC/BCC materials including leaflet, posters, calendar were distributed during the implementation phase. Community Mobilization Events like Folk Song/Drama etc were performed to raise awareness on GBV and engage the community people.

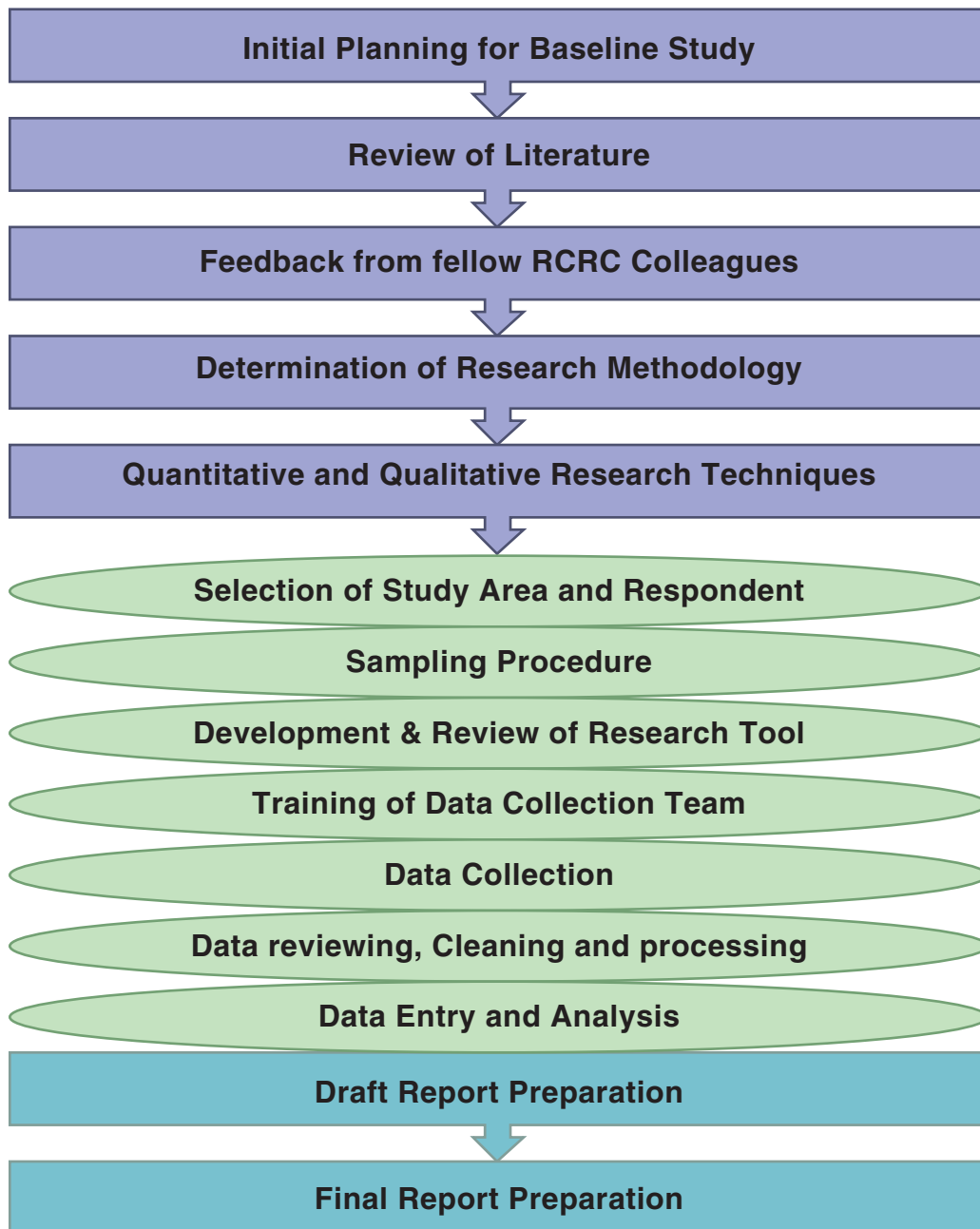
The Baseline Study was done during the second phase of the VP&R Project. The objectives of base line survey are as following.

- To understand the magnitude of gender-based violence in the project area (Khulna, Sathkhira, Barisal and Dhaka)
- To identify the causes and consequences of violence in Bangladesh and its correlation with health
- To develop further plan of action to contribute in prevention of violence and enhance response and referral mechanism
- To assist further project design articulating evidence-based recommendation and findings
- To monitor the changes of gender-based violence after full implementation of Violence Prevention and Repose project

CHAPTER 2

METHODOLOGY

Framework of Baseline Study Research Methodology



2.1 Initial Planning for Baseline Study

Recognizing the importance of research objectives and project requirements, the project team initially conducted a meeting to identify the extent of research and decided to use both qualitative and quantitative research methodologies. It was also decided that the study will be conducted by the project team of IFRC and BDRCS. The meeting output was shared with respective departments and donors and based on the concurrence; the remaining preparations were taken to conduct the study.

2.2 Review of Literature

Prior to initiate primary information collection, the study team opted to gather knowledge on violence prevention and response information from different sources. Existing literatures, as for examples, published articles on Gender based violence and response, Gender based Health, Gender based violence in disaster prone areas in Bangladesh, Gender based Violence, Gender and Diversity in regional and neighboring countries as well as over the world etc. has been reviewed very carefully to collect secondary information. This information not only helped to understand present GBV situation, but also assisted to prepare the data collection tools. Along with reviewing the different articles, the research team also thoroughly studied reading materials, minimum standards, tools and materials published by RCRC.

2.3 Feedback on Gender based Research:

The research team communicated with several researchers who have been conducted Gender researches in regional context. They supported with their utilized research materials, sharing experiences, also scrutinized the research tool that developed for this baseline study and provided their valuable feedback in terms of validity, reliability and ethical aspect.

2.4 Determination of Research methodology

Considering the objectives of the study, the baseline research adopted a mixed study method consisting of both quantitative and qualitative data collection techniques.

2.5 Quantitative Techniques

A Quantitative Cross-Sectional study design was adopted for quantitative part of this study.

2.5.1 Selection of Study Area

Among 5 MCH centers that were chosen for the project, surrounding population of 3 MCH centers was taken to conduct this baseline study, where the first phase of VP&R project was not implemented. The MCH centers are:

1. Tetulia MCH Center, Tala, Shatkhira.
2. Sreefoltola MCH Center, Sreefoltola, Khulna.
3. Jamila khatun MCH Center, Laalbag, Dhaka.

Study population covers 3000 households around each MCH center. So, in total rural and urban population was 9000 households. Sreefoltola and Tetulia MCH Centre are located at the coastal belt area (affected by cyclone), whereas Lalbag Center is located in old Dhaka (mostly affected by fire incidents).



Map: Above showing a map of Bangladesh with administrative border of the districts. Study area districts are dotted in red color in this map.

Remaining two MCH centers were not taken assuming the population is exposed to the idea of violence prevention and response because implementing pilot I phase in 2017/18.

2.5.2 Respondent Selection

It is assumed that the targeted populations to be provided service by the MCH centers are mostly women and children. Also, Literature reviewing has provided convincing evidence that women are usually sufferer of violence than male. Therefore, considering the availability of female participation and the existent rapport as well as familiarity among the female population, this study purposively chosen only female respondents to conduct questionnaire survey.

2.5.3 Sampling

Calculation of Sample Size: The size of the sample has been derived using the following statistical formula (WHO, 1991; Cochran, 1977):

$$n = z^2 * pq / d^2$$

Where,

$z = (1.96)^2$ at 95% confidence level

p = prevalence of exposure which was unknown

therefore considered 50% as per statistical methods.

$q = (1-p) = (100-50) \% = 50\%$

d (design error) = 5%

So, the sample size, $n = (1.96)^2 \times 50 \times 50 / 5^2 = 384.16$

By adjusting the 5% of non-response rate, and rounding the figure, final sample size was determined 405.

Sample Distribution: The determined sample size 405 has been distributed equally among the 3 study areas. Therefore, each area got $405/3 = 135$ sample, which indicates that each data collector collected data from 135 female from 135 household from surrounding areas of respective MCH centers.

As mentioned before, quantitative design of this study has used a purposive sampling method.

2.5.4 Development and Review of Research tool

A structured questionnaire was developed for collection of data from the respondents by using a face to face interview. The questionnaire was prepared after reviewing and studying existing literature, research materials and well examined prior to data collection. Focus Group Discussion and Key Informant Interview checklists were prepared accordingly.

2.5.5 Training of Data Collection Team

A data collection team was prepared consisting of 6 members representing 2 data collectors from each MCH center. The team was prepared before data collection in the field by an intense training explaining Gender Based Research, the difference of GBV research from other researches, interview technique, rapport building, ethical consideration, confidentiality and the rights of the respondents, questionnaire study etc. This team also pre-tested the questionnaire during their training period.

2.5.6 Data reviewing, cleaning and processing

Quality control of collected data has been strictly monitored and supervised during data collection. However, after collection, all data have been rechecked to figure out missing information and gone through cleaning and processing for attaining a quality dataset.

2.5.7 Data Entry and Analyses

Once data was ready, it was recorded in Microsoft Office Excel to formulate a dataset. Later, Data were imported to SPSS for analysis.

Descriptive statistics has been used for data analysis for this study. Variables were measured by frequency and percentage to calculate the extent of violence. Later, analyzed information has been presented in tabular and graphical form in the report.

2.6 Draft Report Preparations:

The report was drafted based on the analysis and compiling all information. Then the report was shared with relevant persons for reviewing.

2.7 Final Report Preparation:

The feedback from the reviewers were addressed and final report was prepared. The report was sent for publication.

2.8 Limitations of this Study

This study has been planned to extract the information regarding violence against women from the catchment community of MCH centers following a scientific social research methodology. Regardless, the context and circumstances did not remain ideal as planned. Consequently, this study also had some limitations which were as follows:

- This study purposively chosen female respondents mainly of reproductive ages who were familiar with MCH activities and MCH centres surrounding areas to get easy access for responding violence relevant questions. Therefore, violence against children, adolescents and men could not be addressed which are also pre-existing in the society.
- Due to time bound and feasibility, only respondents from community were interviewed. While detailed interviewing SGBV activists in respective community both in Govt. and private level could have given a better and clearer picture.

This study has been conducted at selected location considering project areas only. Therefore, although the findings reflect the violence in the community contrasting to other literatures; but it cannot be generalized same way all over the country.

CHAPTER 3

STUDY FINDINGS

Table 1: Socio-demographic Information of the Respondents

Age (mean \pm SD)	27.89 \pm 5.524
Number of family members (mean \pm SD)	4.772 \pm 2.506
Number of male family members (mean \pm SD)	2.387 \pm 1.098
Number of female family members (mean \pm SD)	2.385 \pm 0.085
Income of own/month in BDT (mean \pm SD)	2812 \pm 2121.671
Income of family/month in BDT (mean \pm SD)	12970.22 \pm 10829.537
Proportion of disabled members in family	7.40%

Table 1 shows the socio demographic information of the respondents showing the mean and standard deviation. Overall, approximate age of the respondents was 27, and average family members were 4 including 2 male and 2 female members. The average personal income was around BDT 2,800 and family income was around BDT 12,000. Proportion of disabled person in family is 7.40%.

Table 2: Religion and Marital status of the Respondents

Variable	Percentage
Religion	
Islam	96.0
Hindu	4.0
Marital Status	
Never married	0.5
Married	97.0
Separated or Divorced	0.5
Widowed	2.5

Table 2 shows religious and marital status of the respondent. Among the total, 96% respondents were Muslim and 4.0% was Hindu. Overall, 97% respondents were married, while remaining 3% respondents never married, separated or divorced and widowed.

Table 3: Information of Education and Occupation (respondents' and their husbands')

Variable	Percentage (Respondents)	Percentage (Respondent's Husband)
Education		
No formal education	51.6	37.2
Primary	35.3	34.4
Secondary	9.5	18.6
Higher secondary	1.8	7.6
Graduate or more	1.7	2.3
Occupation		
Homemaker	86.2	0.1
Service (Govt/non Govt)	1.2	12.8
Business	0.0	41.6
Day labor	6.4	20.1
Others	6.2	25.5

Table 3 shows information on proportion of education and occupation of the respondents. Around 51% respondents did not get any formal education where 37.2% of their husband got formal education. Around 34% of the respondents and 35% of their husband got primary education. Proportion of higher education is very low. Only 1.7% among respondents and 2.3% of their husbands have graduate or more educational qualification.

Occupation wise, 86% respondents was homemaker and only 0.1% of their husbands did not have any established job, 12% of the respondents' husband found doing govt. or private service where only 1.2% respondents found doing so. Nobody among respondents found doing businesses but 41.6% among the husbands doing business. Around 6% of the respondents with 20.1% husbands doing day labor. Among husbands, 25.5% and respondents 6% found doing other kind of works such as, tailoring, driving, chef, farmer etc.

Table 4: Marital age of Respondents

Age in years	Frequency	Percentage
Below Age 12 years	22	5.4
Between 13 to 15 years	224	55.4
Between 16 to 17 years	127	30.7
Age 18 years +	32	9.7
*(mean \pm SD) = 15.04 \pm 2.052		

Table 4 shows the ages of the respondents during their marriage and it clearly indicates that majority of the respondents faced early marriage and got married below 18 years. There were only 9.7% response on getting married above the age of 18. In total 5.4% respondents got married below 12 years of age, more than half of the respondents got married in between 13, 14 and 15 years, proportions are respectively 15.6%, 15.8%, 24.0%; in total 55.4%. In between 16 to 17 years, 30.7% got married. Even at 9 years of age of marriage found in data (1.5%). Table one also shows that the mean age of the respondents while getting married is around 15 which clearly indicate that the extent of child marriage in study population.

Table 5: Age of Respondents' 1st pregnancy

Age in years	Frequency	Percentage
Below Age 15 years	50	12.9
Between 15 to 18 years	300	76.7
More than 18 years	41	10.4
*(mean \pm SD) = 16.72 \pm 7.044		

Table 5 shows the age of the respondents when they became pregnant for the first time. This is a very alarming finding showing around 76% 1st pregnancy to be happened in between age of 15 years to 18 years, even 13% pregnancy below 15 years. Only 10.4% respondents got pregnant for the first time above 18 years.

Figure 1: Response on healthcare seeking behaviour in percentage

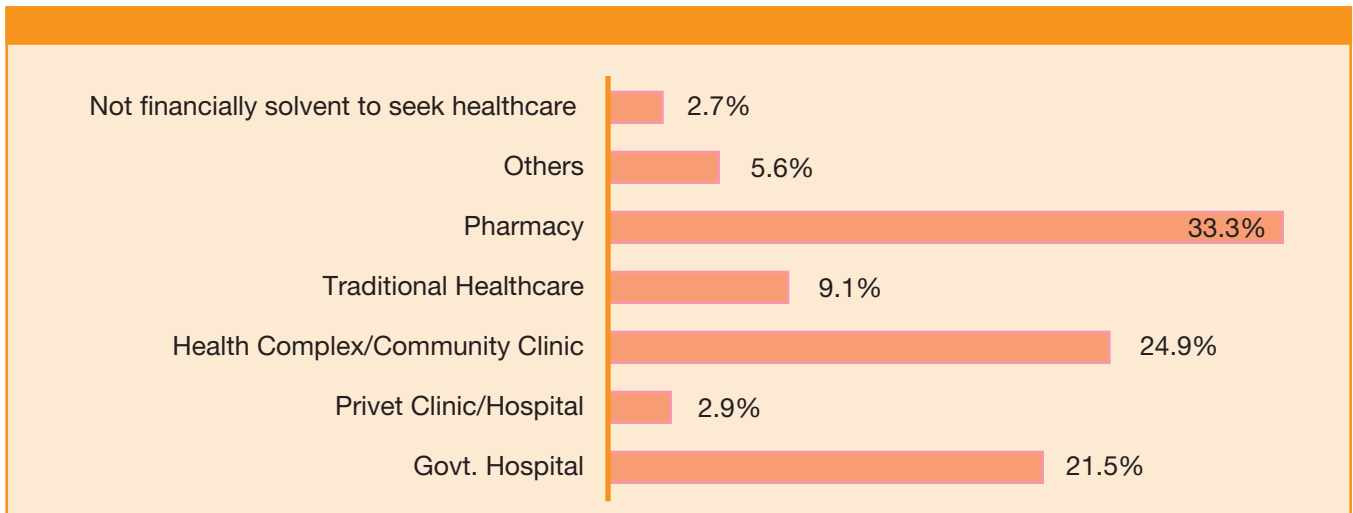
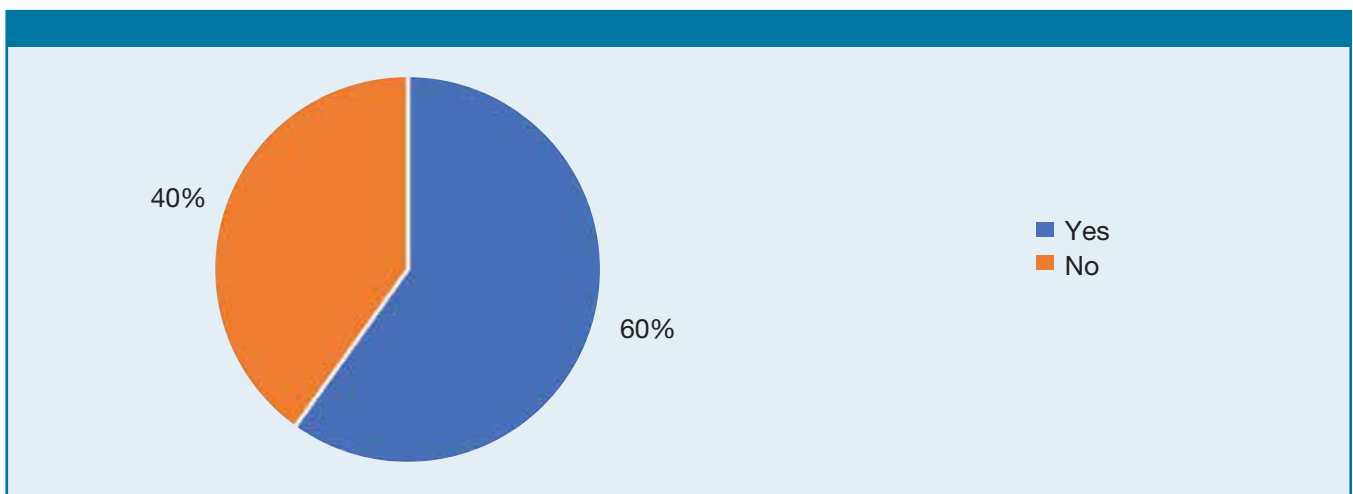


Figure 1 shows respondents' healthcare seeking behaviour. Around 21% seeks healthcare for Govt. Hospitals, 25% from Health complex or community clinics supported by gov. or NGOs, only 2.9% from private clinics, 9.1% from traditional way (example: Kabiraj, homeopath, Ayurveda etc.), 33.3% mentioned about getting healthcare from pharmacy, 5.6% mentioned other methods like going to religious leaders, 2.7% mentioned having no financial ability of seeking health care.

Figure 2: If the healthcare providing centre is far from home



The respondents were further asked if the healthcare centres are far from their place of living. Around 60% agreed to have healthcare providing centres far from their place of living.

Figure 3: Access to ANC (Ante-natal care) during pregnancy

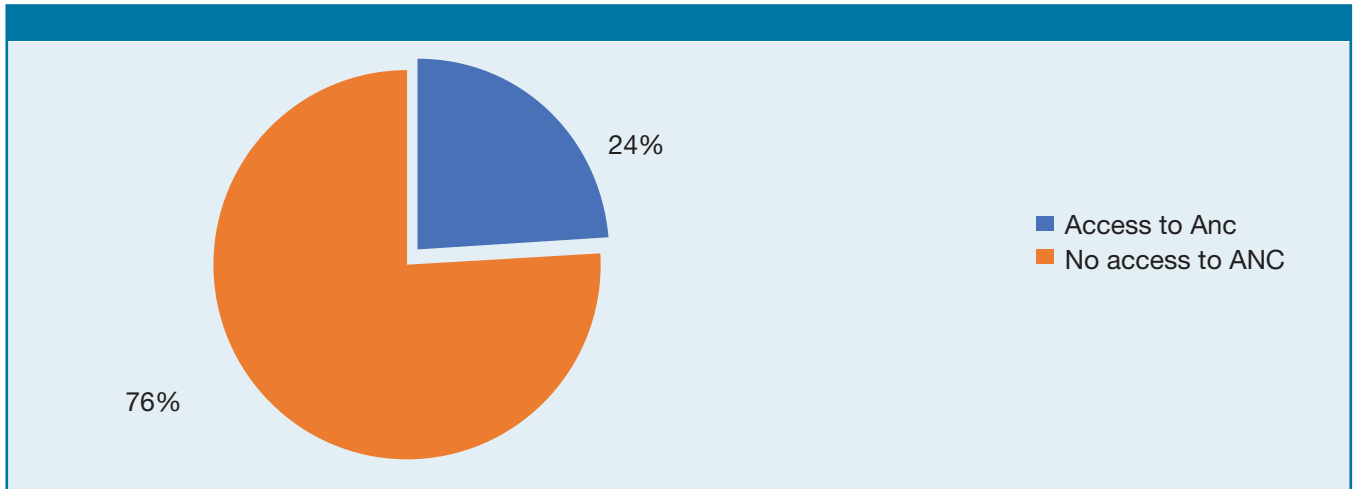


Figure 3 demonstrates the status of accessing anti-natal care during pregnancy by the respondents. In total, 76% has no access to ANC while 24% got ante-natal care during their pregnancy period.

Figure 4: Place of childbirth within last one year in percentage

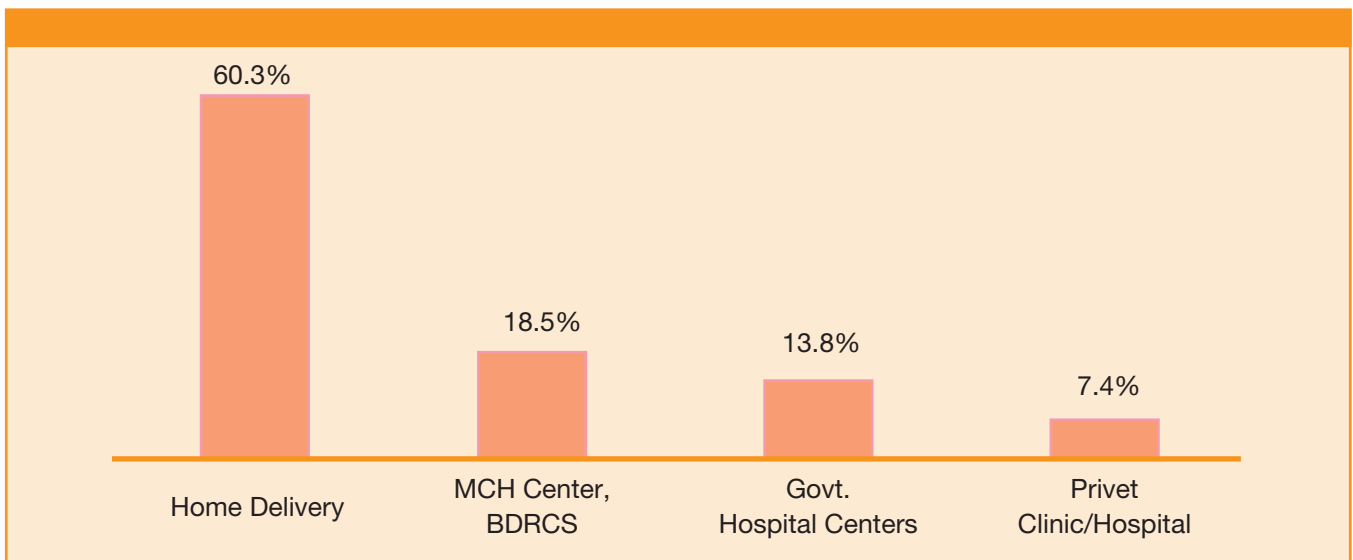


Figure 4 represents the places of birthplace within last one year in percentage. During the survey, the Respondents were asked on place of childbirth in case of any in last one year. Around 60% got child delivery in home, 19% at MCH centres of BDRCS, 13.8% from Govt. hospitals or supported centres and 7% from Private Hospitals or clinics.

Figure 5: Reason of Childbirth at home in percentage

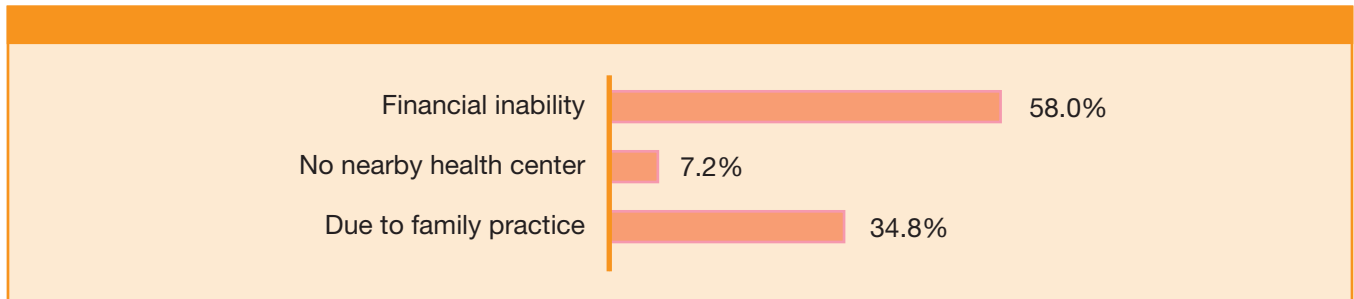
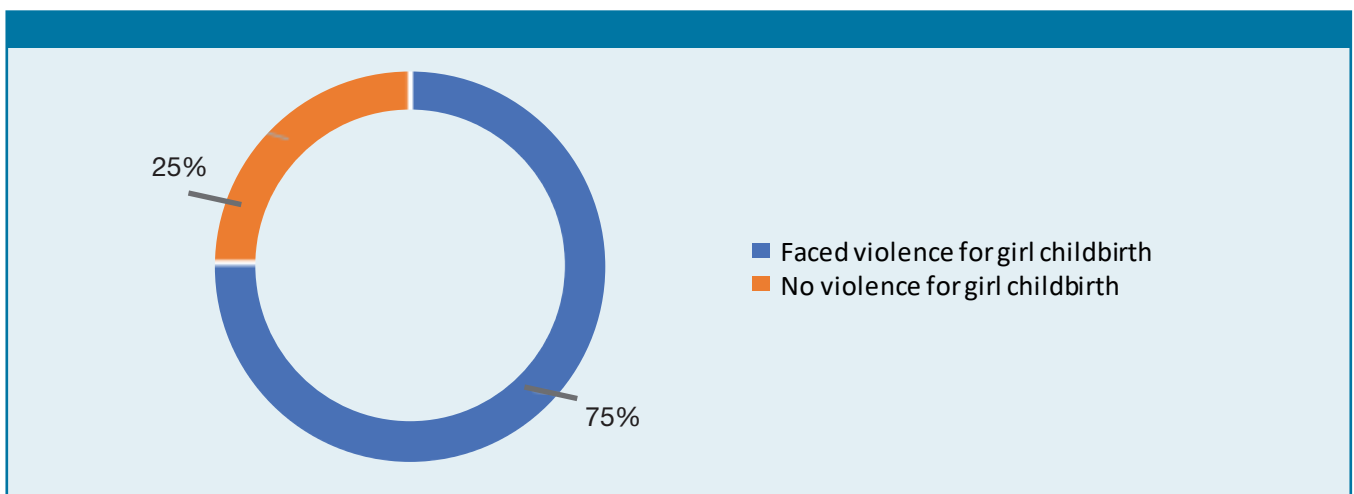


Figure 5 illustrates the reasons for childbirth at home in percentage. Respondents who had childbirth at home further asked about the reason of home delivery. Around 58% expressed their financial inability to get hospital/-clinical care, 35% mentioned about conservative family norms of giving birth at home and 7.2% mentioned of having no nearby healthcare centres around.

Figure 6: Violence faced by the respondents after girl childbirth



While the respondents were asked if they faced any violence in case of giving birth to a girl child, approximately 75% agreed on facing violence for girl child birth.

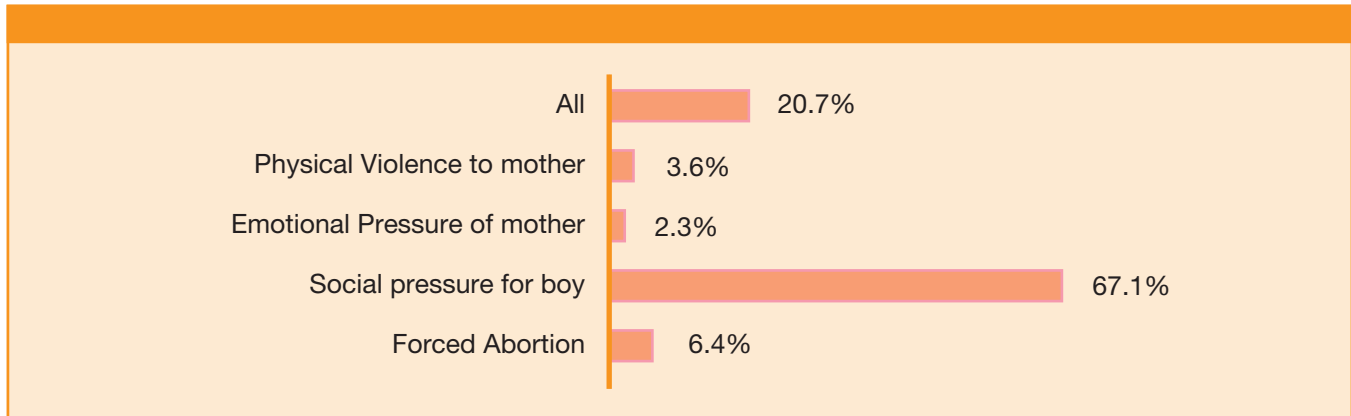
Figure 7: Type of violence faced by mother after girl childbirth (%)

Figure 7 shows the response of mothers on the types of violence faced after giving birth to a girl. Around 67% mentioned of having the social pressure for a boy child and 6% faced forced abortion; 3.6% faced physical torture and 2.3% faced emotional pressure, around 20% of the respondents who gave girl childbirth faced all of this different kind of violence together.

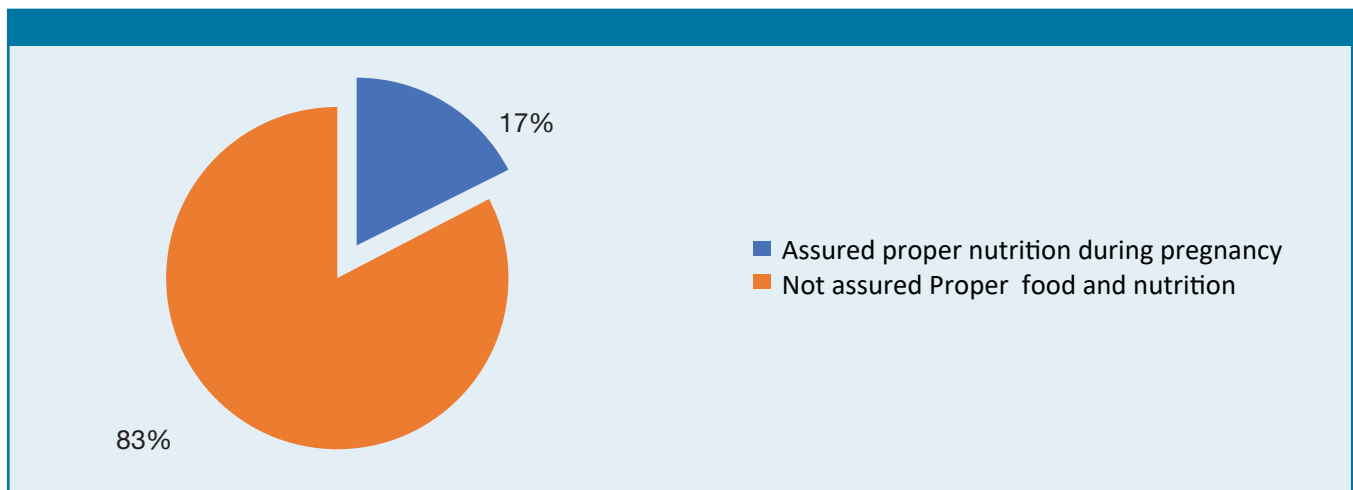
Figure 8: Availability of proper food and nutrition during pregnancy

Figure 8 represents the availability of proper food and nutrition during pregnancy. When respondents were asked if they got proper food and nutrition to be received for an expecting mother around 83% said that they did not get proper nutrition food and nutrition that were needed during pregnancy, while only 17% pregnant mothers got the food.

Figure 9: Availability of proper physical and mental support during pregnancy

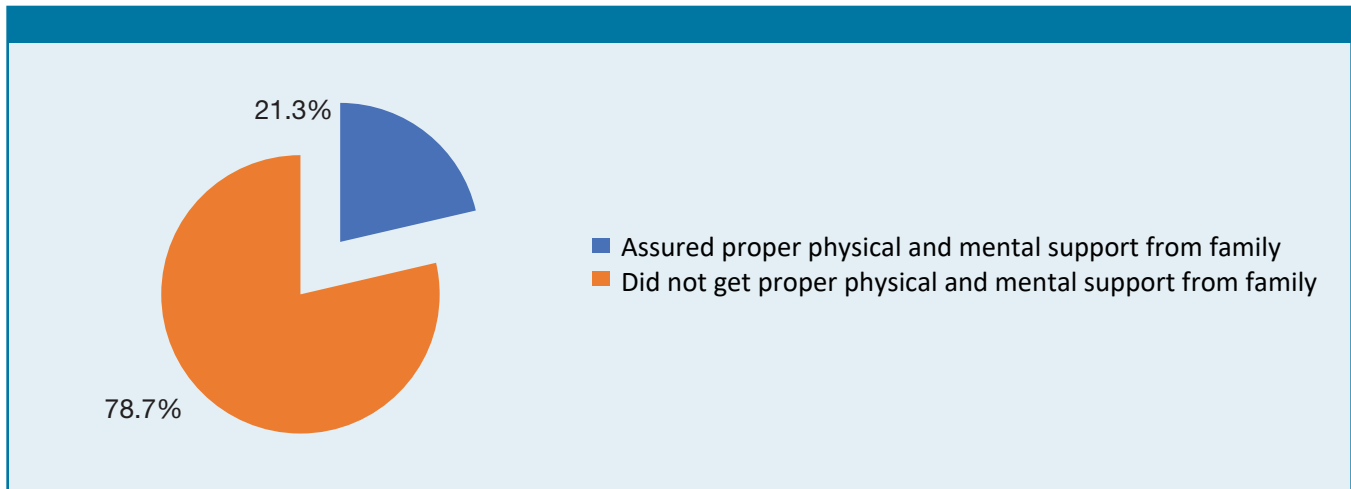


Figure 9 shows the status of physical and mental support during pregnancy by their family. Out of the total, only 21.3% female mentioned that they got the physical and mental support form family while the largest portion of female (78.7%) total that they were deprived from any physical and mental support from family during their pregnancy.

Figure 10: Food portion given to the household members in percentage

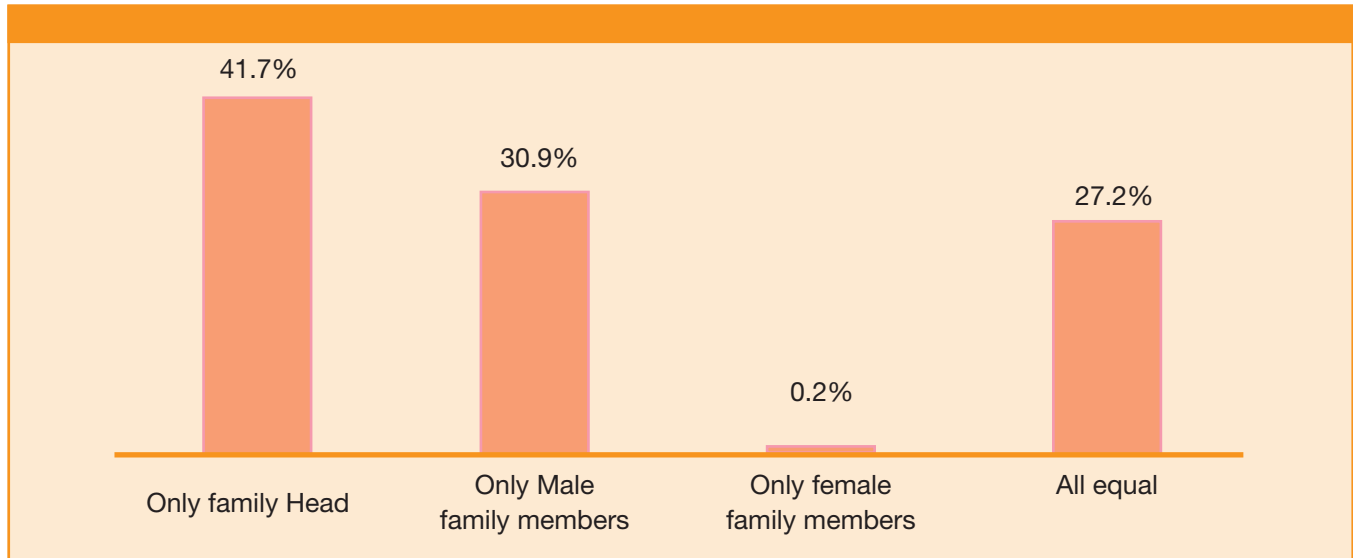


Figure 10 above shows that how food portion was distributed among the family member. According to the data, only family heads are given the larger and better food portion which is 41.7%, in Bangladesh country context the family heads are male, so it is obvious that Family Heads are usually male which is reflected in the next result which says 30.9% respondents responded only male members in the family receive the better portion of the food. In 27.2% cases foods are equally distributed and only in 0.2% cases female family members are given the larger and better portion of the meal.

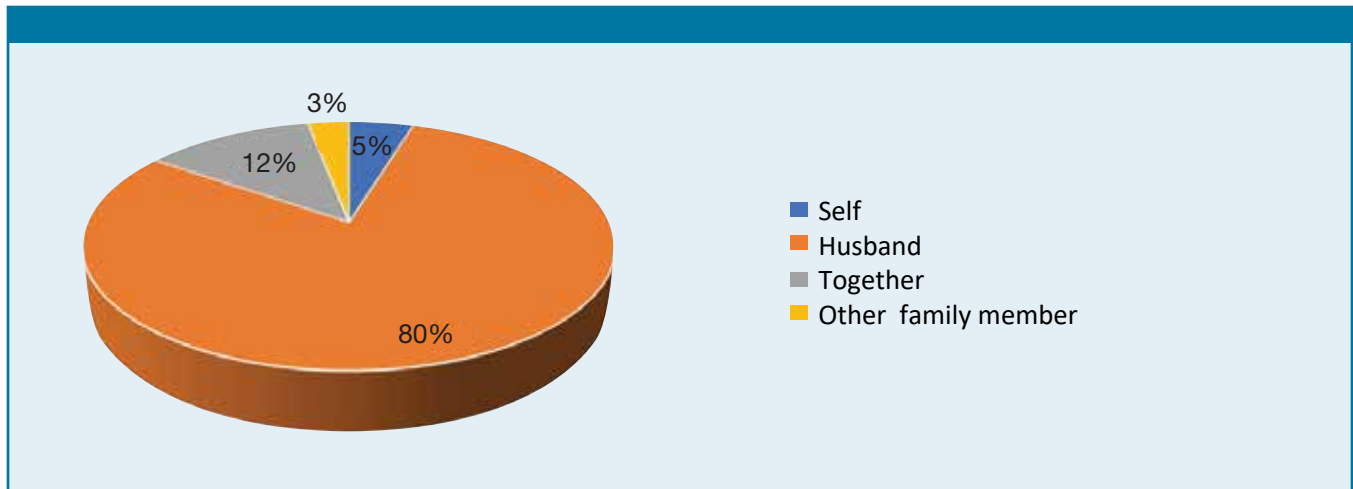
Figure 11: Household decision making for foods and cloths

Figure 11 above shows that husband in the family was the main decision maker regarding foods and cloths which was 80% cases. Only in 12 % cases the decisions are taken together, in 5% cases the respondent can take this decision by herself and 3% respondents mentions that the decision is taken by other family members.

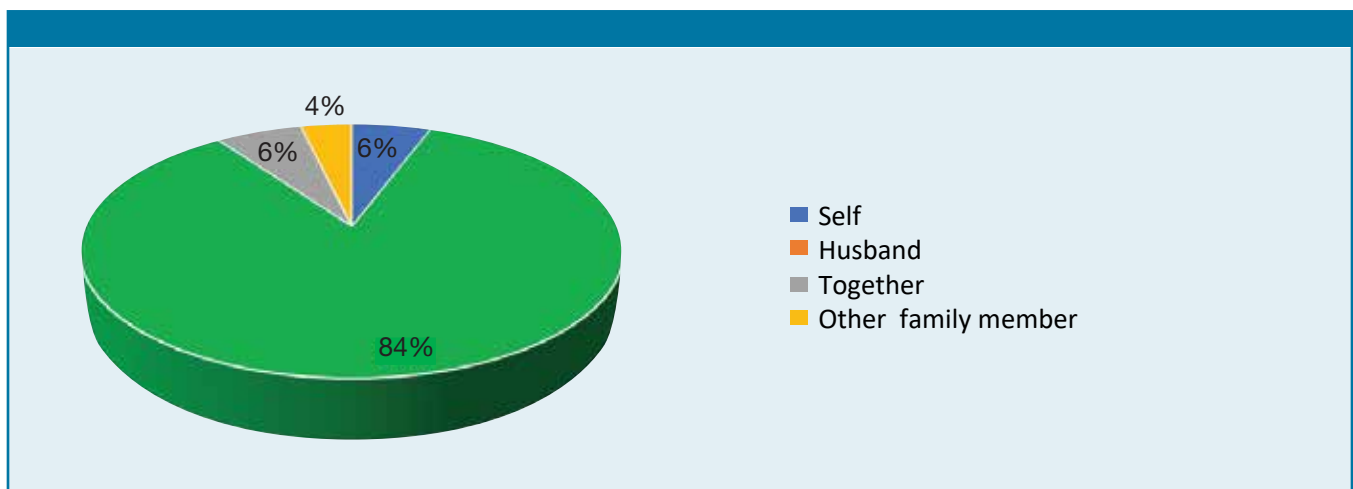
Figure 12: Household decision making for getting health services

Figure 12 shows how decisions were taken for getting health services. Here, same as earlier, Husband in the family was the main decision maker regarding Health which is in 84% cases. Only in 6% cases the decisions were taken together, in 6% cases the respondent took this decision by herself and 4% respondents mentions that the decision was taken by other family members.

Figure 13: Household decision making for large investments

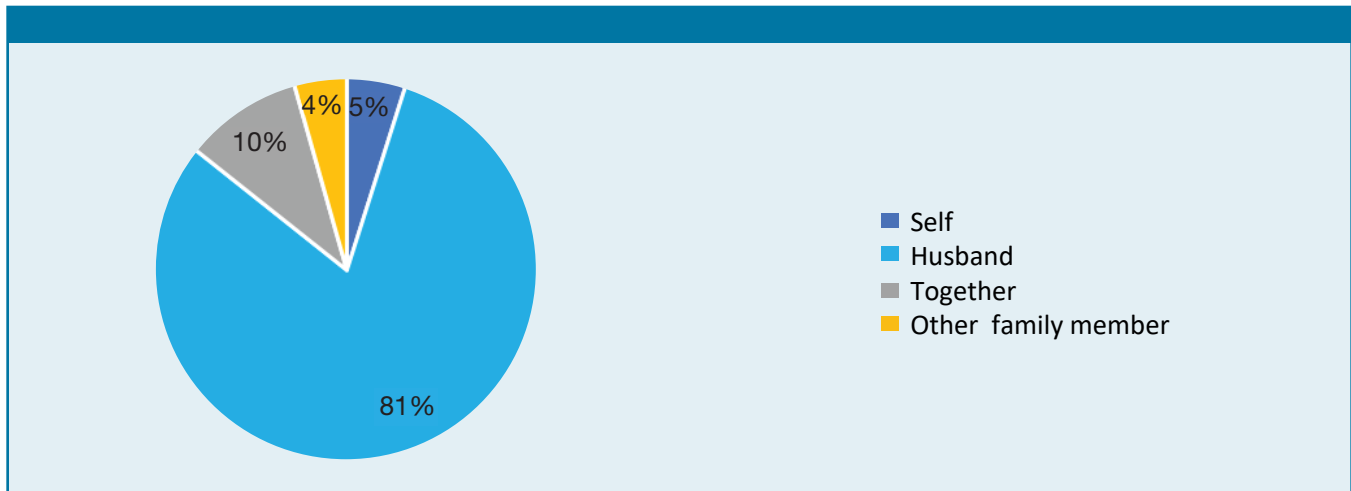


Figure 13 shows how decisions were taken in the family for large investment. It was revealed that Husband in the family is the main decision maker regarding large expenditure or investment which was in 81% cases. Only in 10% cases the decisions were taken together, in 5% cases the female member took this decision by herself and 4% respondents mentions that the decision was taken by other family members.

Figure 14: Household decision making for Education

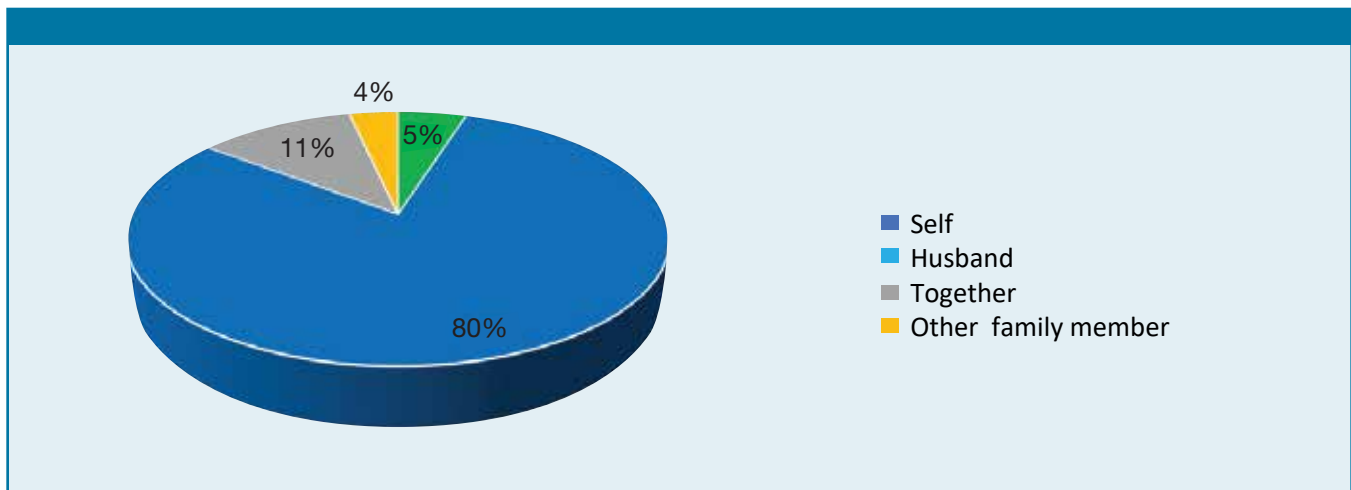


Figure 14 shows how decisions were taken while getting education by family members. Same as earlier, the pie chart reported that Husband in the family was the main decision maker regarding Education which was 80%. Only in 11% cases the decisions were taken together, in 5% cases the female member took this decision by herself and 4% respondents mentions that the decision was taken by other family members.

Figure 15: Household decision making for marriage of children

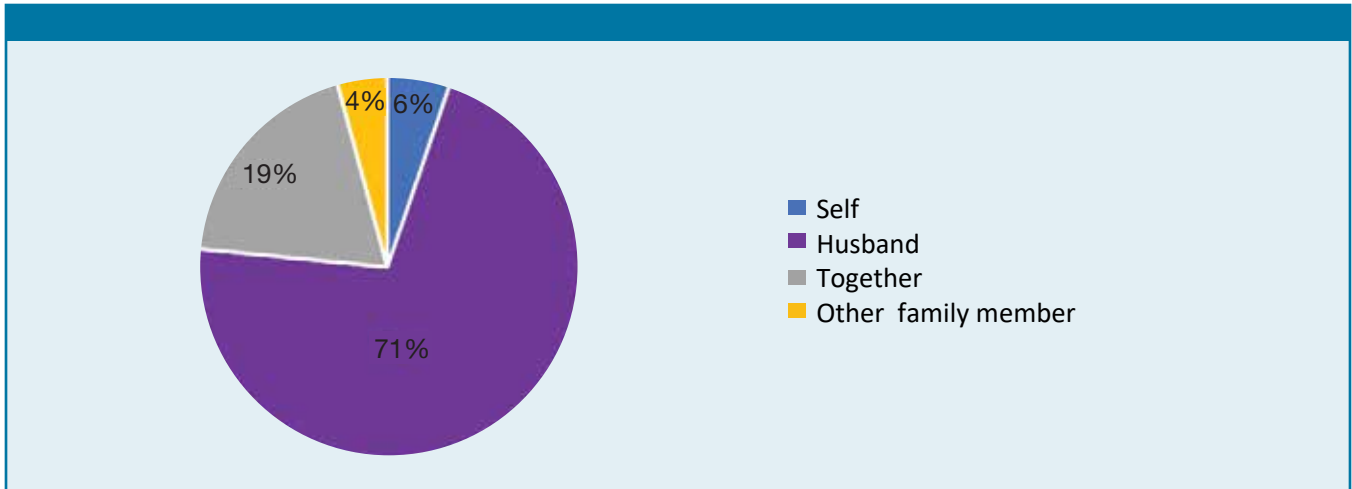


Figure 15 shows that Husband in the family is the main decision maker regarding marriage of children which is in 71% cases. Only in 19% cases the decisions were taken together, in 6% cases the female member took the decision by herself and 4% respondents mentions that the decision was taken by other family members.

Figure 16: Household decision making for family planning

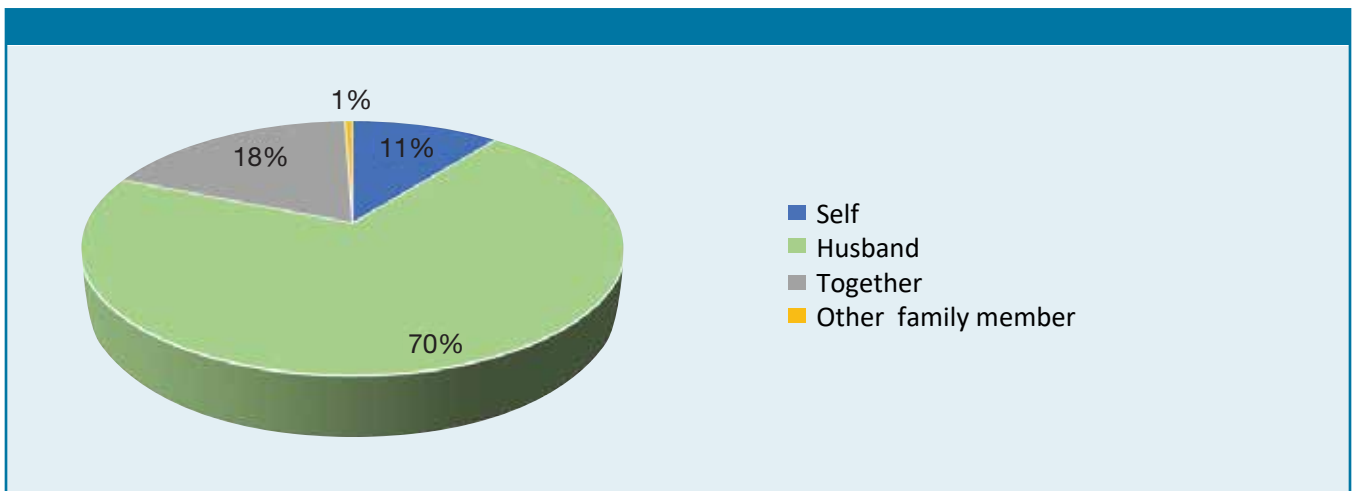
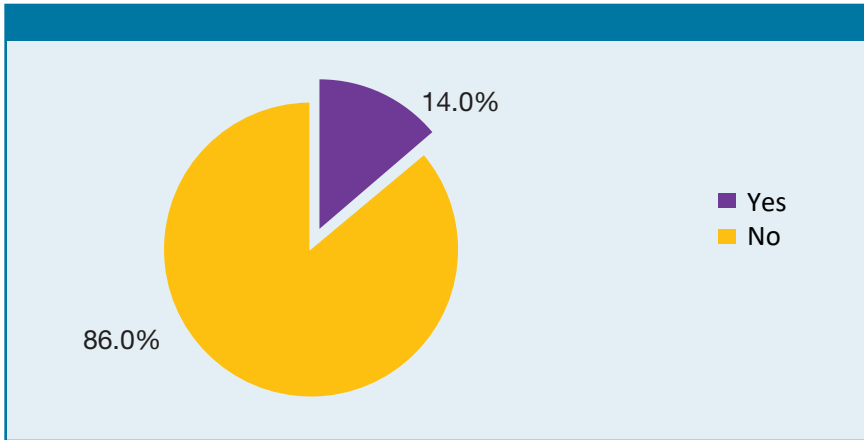


Figure 16 shows that Husband in the family was the main decision maker regarding family planning which is in 70% cases. Only in 18% cases the decisions were taken together, in 11% cases the respondent took this decision by herself and 1% respondents mentions that the decision is taken by other family members.

Figure 17: Access of movement to family



Respondents were asked about their freedom of movement in different places. Only 14% respondent can go to their own family or friends' house without the concern of taking permission from husband or other family members, where 86% cannot go at none of those places without permission. As figure 18 shows

Figure 18: Access of movement to Healthcare Centers/hospitals

Figure 18 illustrates the status of movement of the respondents to healthcare centers. Data reveals that, only 24% can go to healthcare centers or hospitals without the permission of their family members, while 76% family could not go healthcare center without the permission of family member.

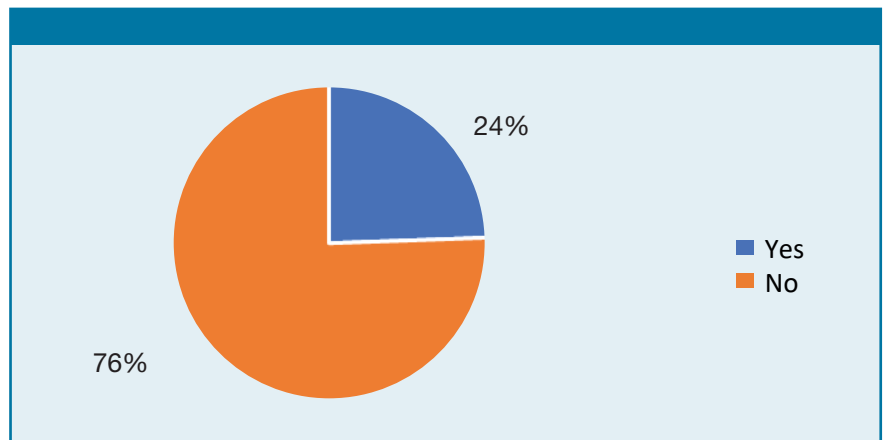


Figure 19: Access of Movement to any other places

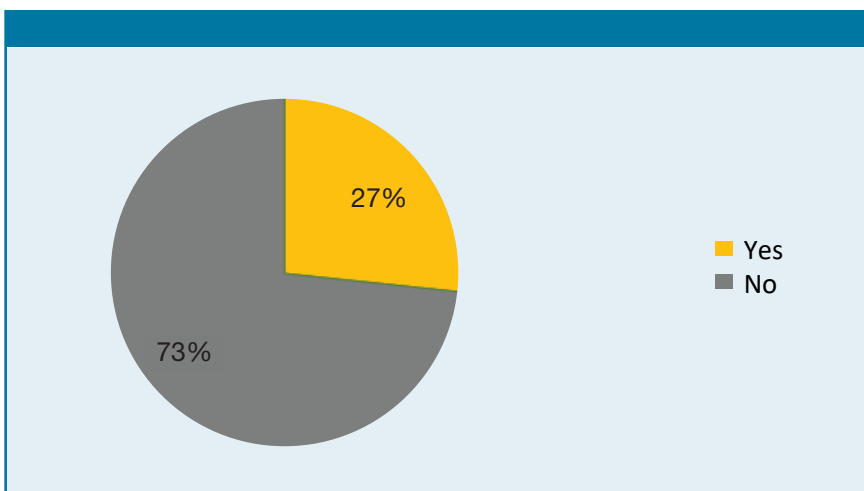


Figure 19 shows the movement of female members of the households to any meetings and other places based the permission of husbands. Only 27% respondent can go to their own family or friends' house without the concern of taking permission from husband or other family members, while the greater portion (73%) cannot go at none of those places without permission

Figure 20: Proportion of respondents faced violence in their lifetime

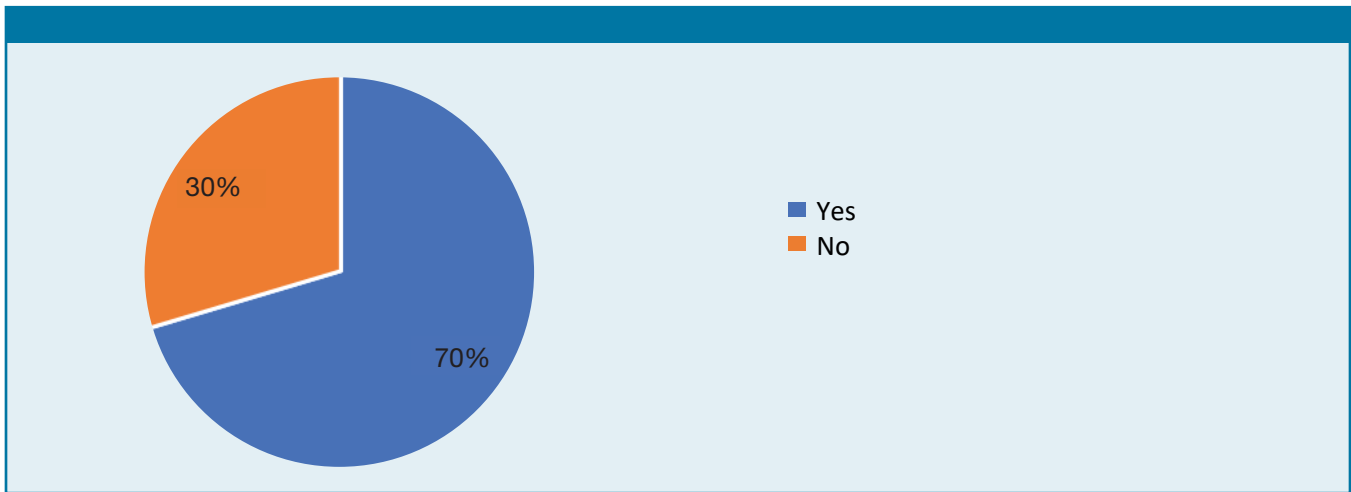


Figure 20 illustrates about whether the respondent faced any violence in their lifetime or not. According to the data, it was found that largest portion of respondents (70%) faced violence at some point of their life, while only 30% mentioned that they have not faced any violence ever.

Figure 21: Types of violence faced by the respondents (*Multiple responses)

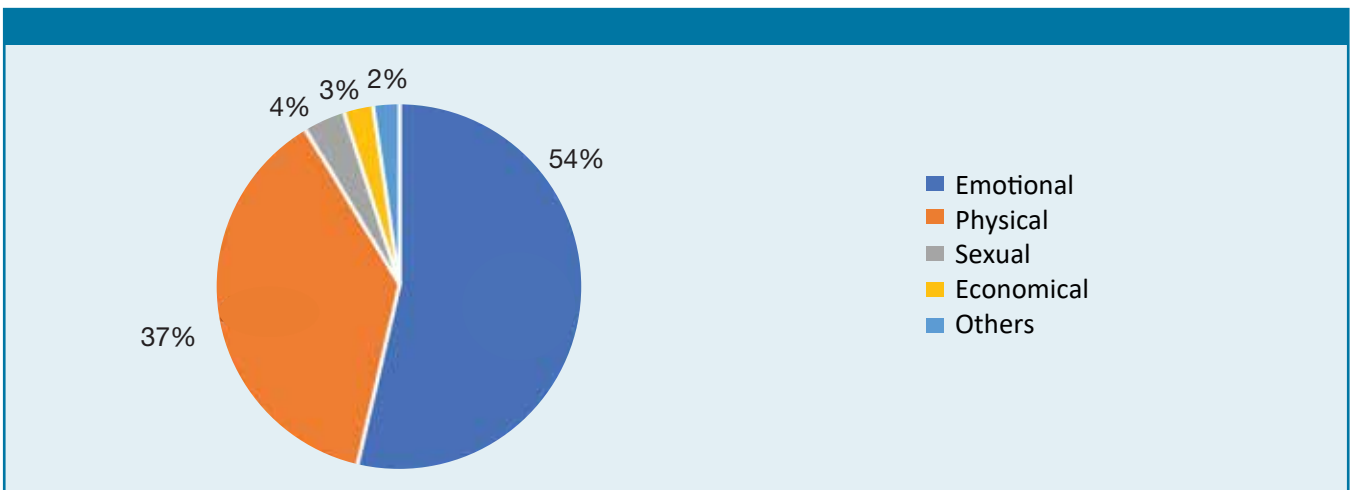


Figure 21 reports on the types of violence faced by the female, who faced violence in the previous graph. Among different types of violence respondents mostly faced emotional violence which was 54%. The second highest violence was physical (37%). While sexual assault was 4%, economical was 3% and only 2% faced other types of violence that they could not categorized.

Figure 22: Causes of violence

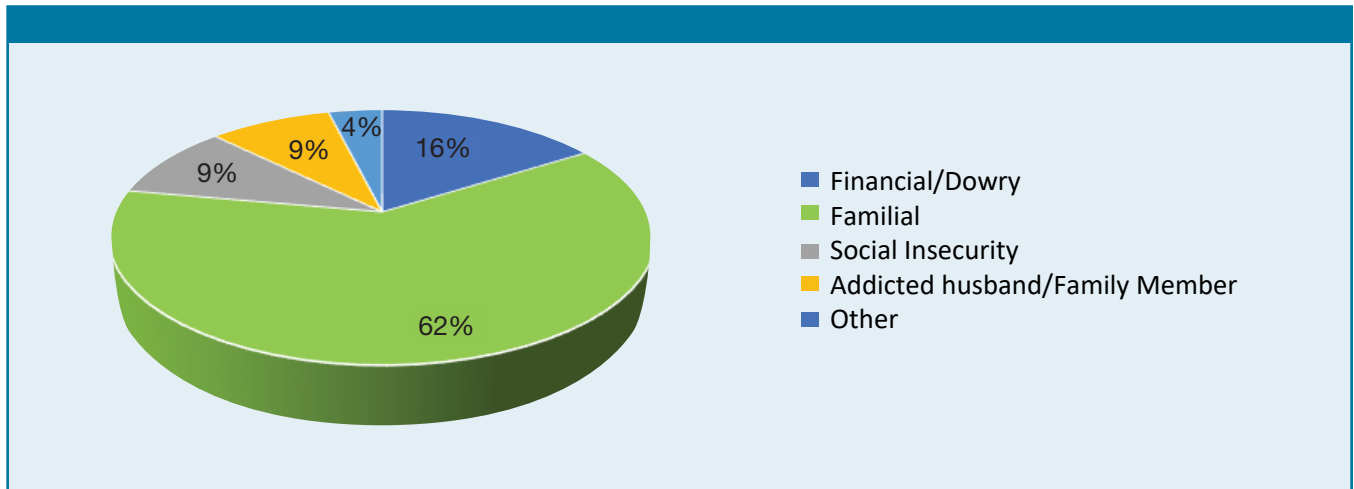


Figure 22 shows the cases violence in the communities. Respondents were asked about the reasons of different kind of violence were as they faced. It was found that the highest reason of violence was familial, which was 62%. The second highest cause was dowry (16%). For the both cases like social insecurity and addicted partner, their figures were same (9%). And, only 4% cases they did not identified the reason of violence.

Figure 23: Consequences of violence among respondents in percentage

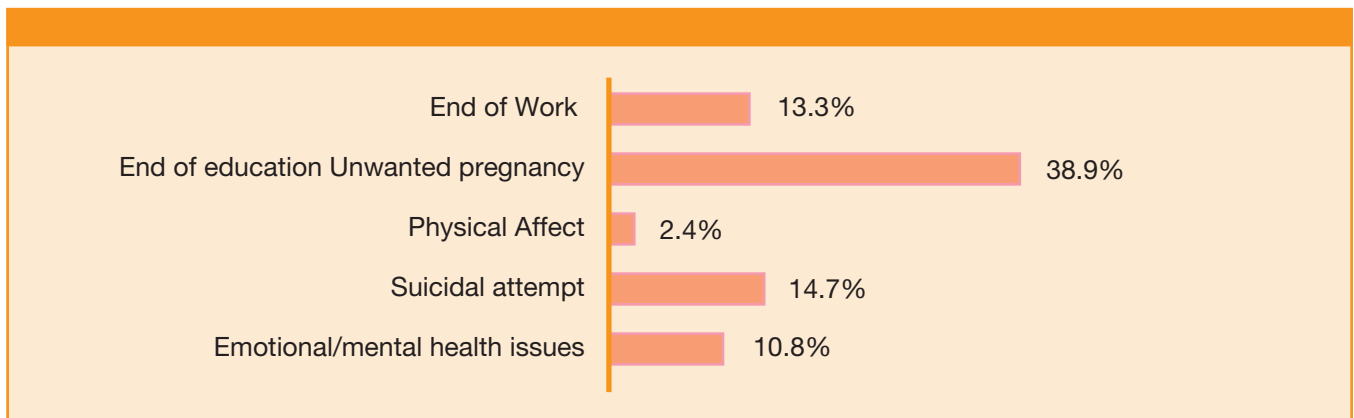
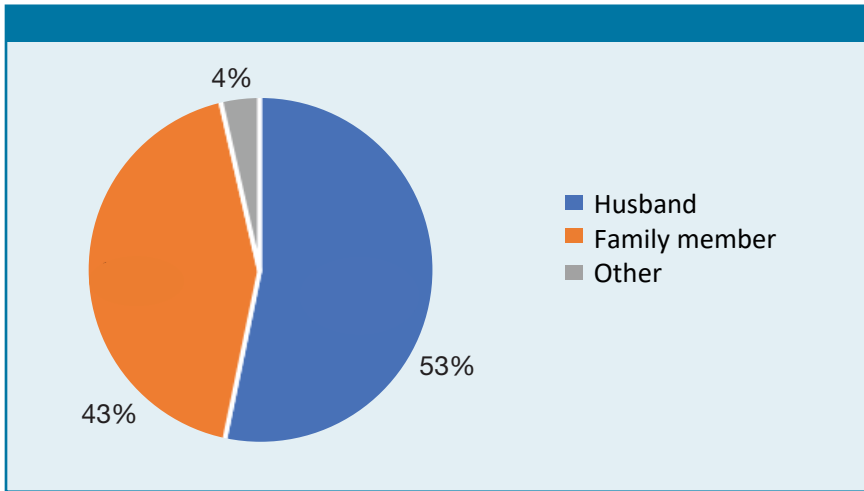


Figure 23 shows the consequences of violence as the responded faced which happened during their lifetime. The highest percentage was 38.9%, when female had to end their education. In 17.9% cases they were physically affected. 13.3% mentioned that they had to end their work because of the violence, 14.7% attempted for suicide and 10.8% has faced emotional and mental health issues because of the violence they faced. Dangerously, 2.4% had to have unwanted pregnancy due to violence.

Figure 24: Preparator of Violence in percentage



Respondents were asked who caused the violence they faced in their lifetime. Figure 24 shows the preparator of violence. There, 53% mentioned that they had faced it because of their husbands, 43% mentioned their other family members were responsible for the violence, and only 4% mentioned other people rather than any family member were the reason behind the violence as they faced.

Figure 25: Proportion of the survivors sought for help after violence

Figure 25 shows whether the survivors got any help or not while they shouted for assistance. The greater portion 61% female told that they did not sought any help. Among the total 39% cases they sought for help.

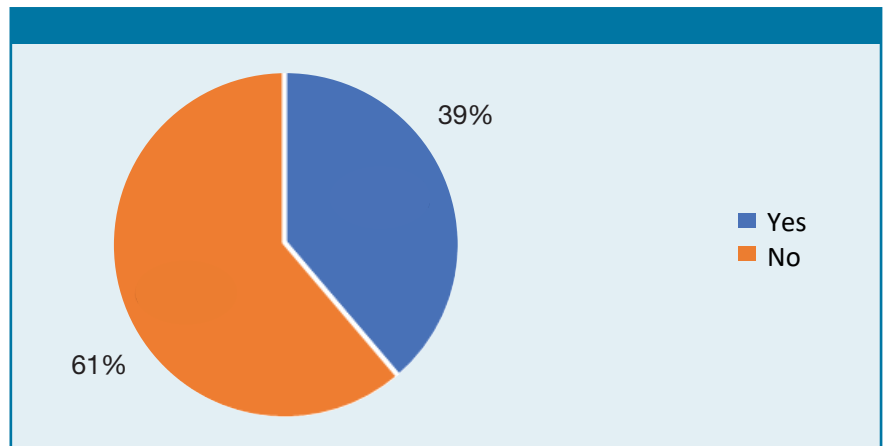


Figure 26: Proportion of the violence survivors got assistance/help

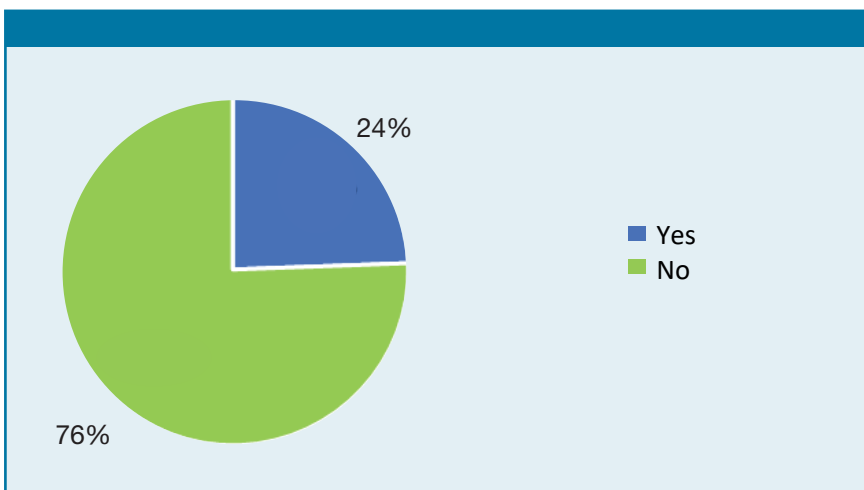
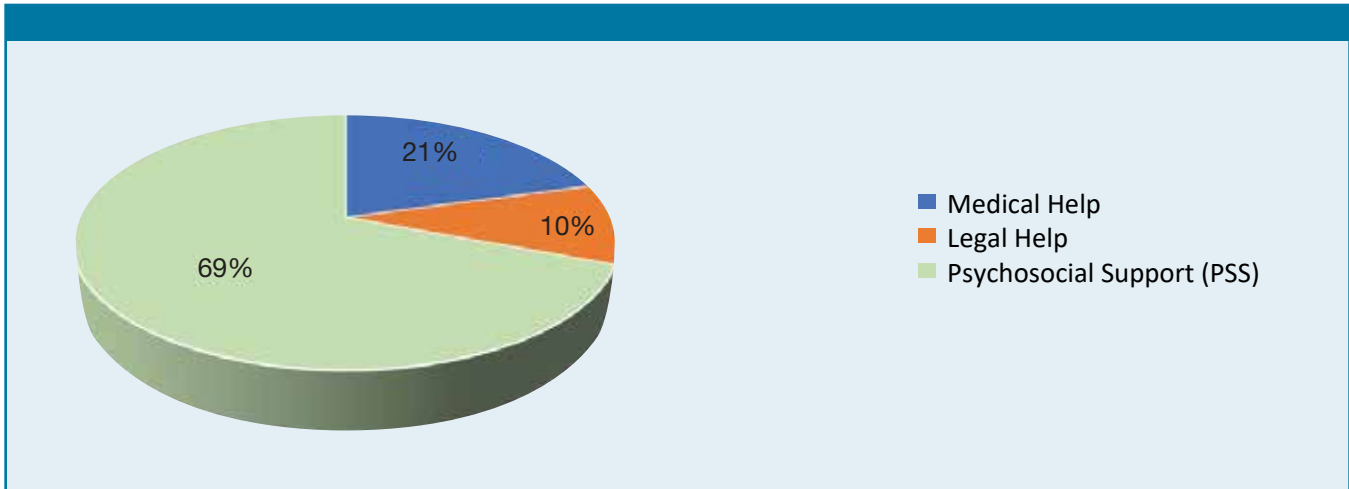


Figure 26 shows, among them who sought help for the violence they faced, asked again whether they got assistance or not. It was found that 24% got assistance while bigger portion (76%) did not get any assistance they sought for.

Figure 27: Types of help survivors got after asking assistance



The respondents asked again on the kind of help/assistance they sought for responding the violence they faced. Figure 27 reported that most of the survivors (69%) got psychosocial support, secondly 21% survivors got medical help, and only 10% got legal assistance.

Figure 28: Barriers for responding violence in percentage

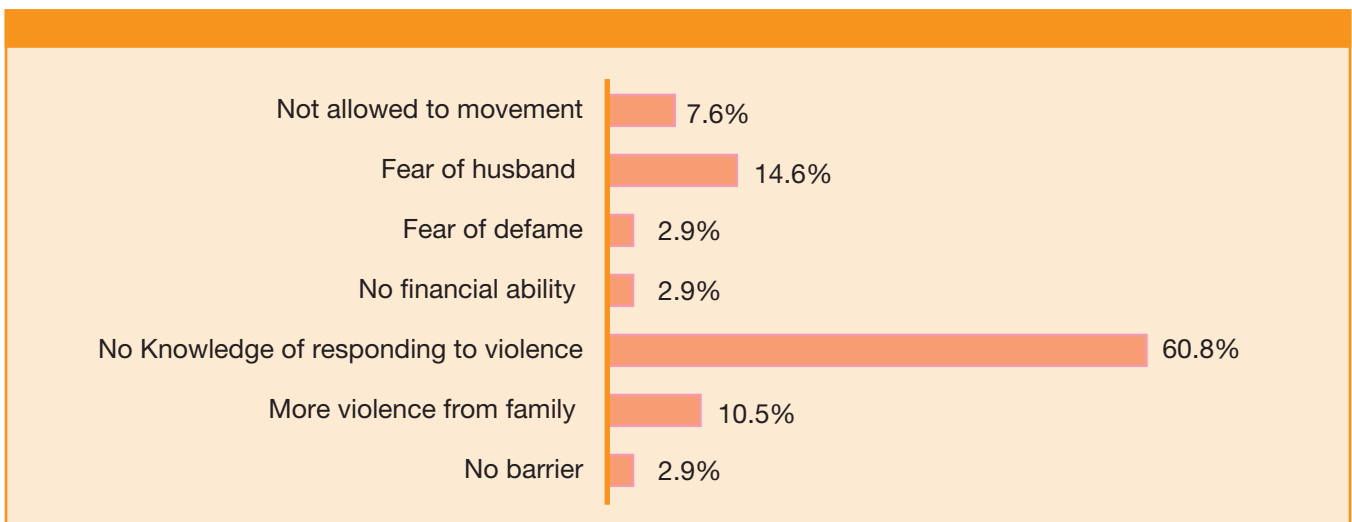


Figure 28 illustrates the barriers for responding violence. When the respondents were asked about what the barriers were for responding against the violence that they faced, the highest portion, 60.8% told that they had no knowledge on how to respond violence. Secondly, 14.6% did not respond violence due to the fear of husband. Thirdly, 10.5% reported that they might be faced again violence if they respond against the violence. And, 7.6% found they have limited movement restrictions. Only around 3% survivors thought that they did not have any barrier for responding against violence.

Figure 29: Restriction for getting job, going to work or earning money by husband and family member

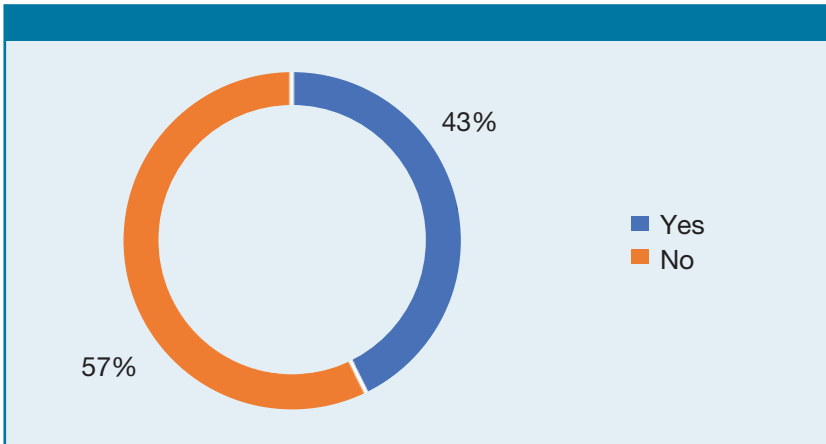


Figure 29 shows where the female members have any restrictions for getting job, going to work or earning money by husband and family member or not. Data showed that 57% had the restriction to get job, go for work and earn money by the husband and family member while 45% did not have such kinds of restrictions.

Figure 30: Forceful handover of earned money to husband/family member

Figure 30 shows, respondents were asked whether they have ever faced forceful seize of their own money or not. The biggest portion, 57% responded that they do not face this kind of forceful handover of money. However, 43% have such kinds of experiences

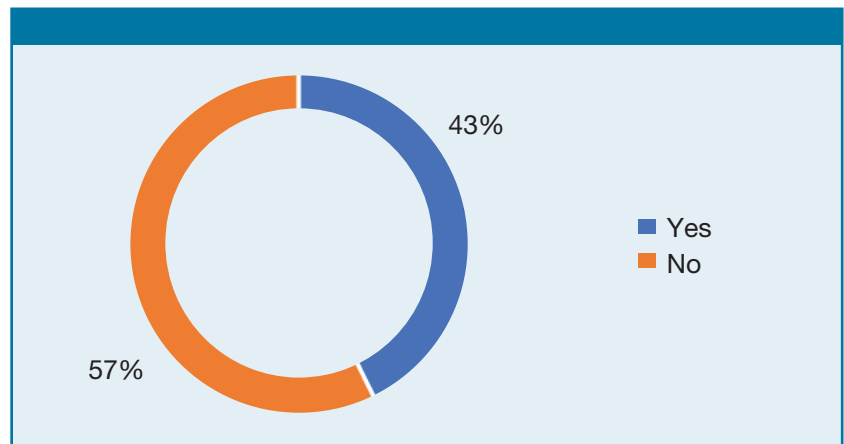


Figure 31: Forceful removals from home by husband/family member

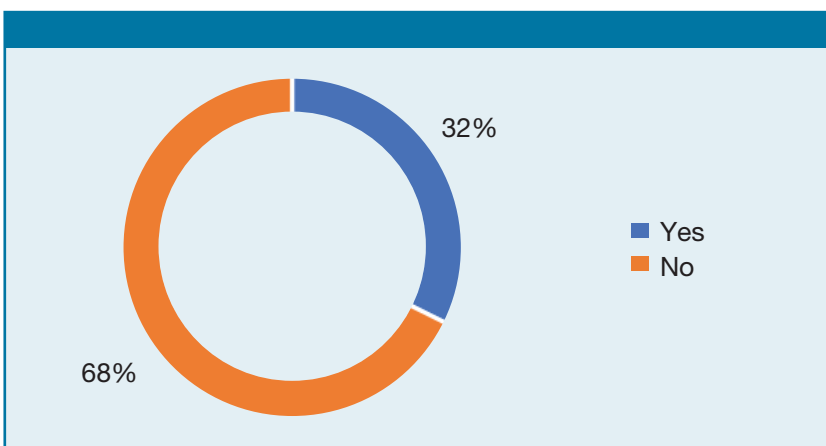


Figure 31 shows, respondents were asked were they have been forcefully thrown out of their home or not. Out of the total, 68% female responded that they did not faced any forceful removals from home. However, 32% female have the such kinds of experience.

Figure 32: Opinion/Acceptance on getting hit by husband

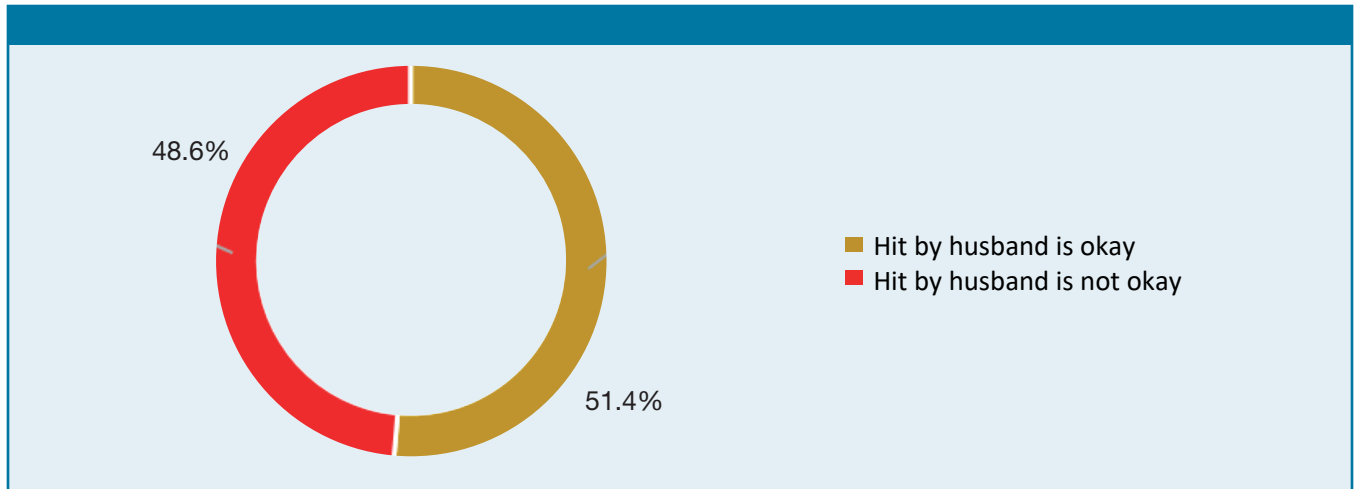


Figure 32 shows whether getting hit by husband is okay or not. More than half of the respondents think that getting hit by husband was okay of them. On the other hand, 48.6% think that it was not right.

Figure 33: Knowledge of respondents about the age of marriage for a male

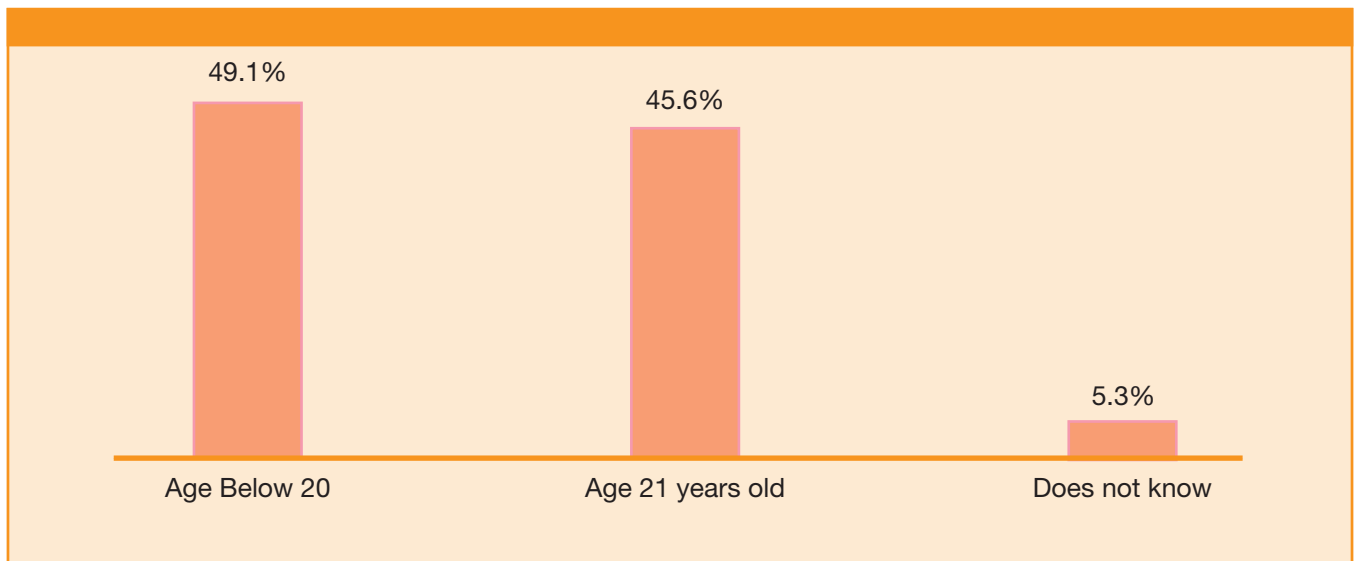


Figure 33 demonstrates the knowledge of respondents about the age of marriage of a male. Responding to the question, 49.11% replied that a should marry below the 20 years of age. Secondly 45.6% responded either 21 or above should be the age of a man to marry, while 5.3% responded as they do not know.

Figure 34: Knowledge of respondents about the age of marriage for a female

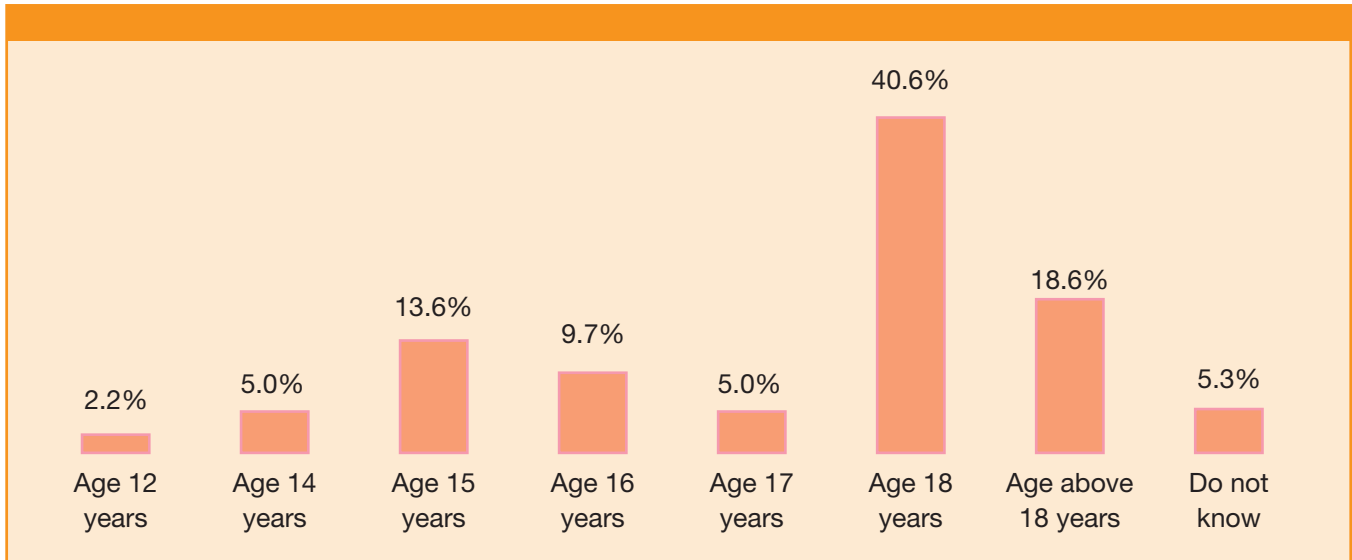


Figure 34 clearly illustrate the variation of ideas on marital age for female among the community compared to male shown in picture 33. Respondents were asked at what the age a woman should get married and surprisingly 2.2% mentioned 12 years should be an ideal age, 5.0% responded 14 years, 13.6% mentioned 15 years, 9.7% responded 16 years and 5.0% mentioned 17 years be an ideal age for marriage for female; 40.6% responded 18 years should be the ideal age and 18.6% mentioned above 18 years, while 5.3% said that they did not aware about the age of marriage.

Figure 35: Importance of dowry in a marriage

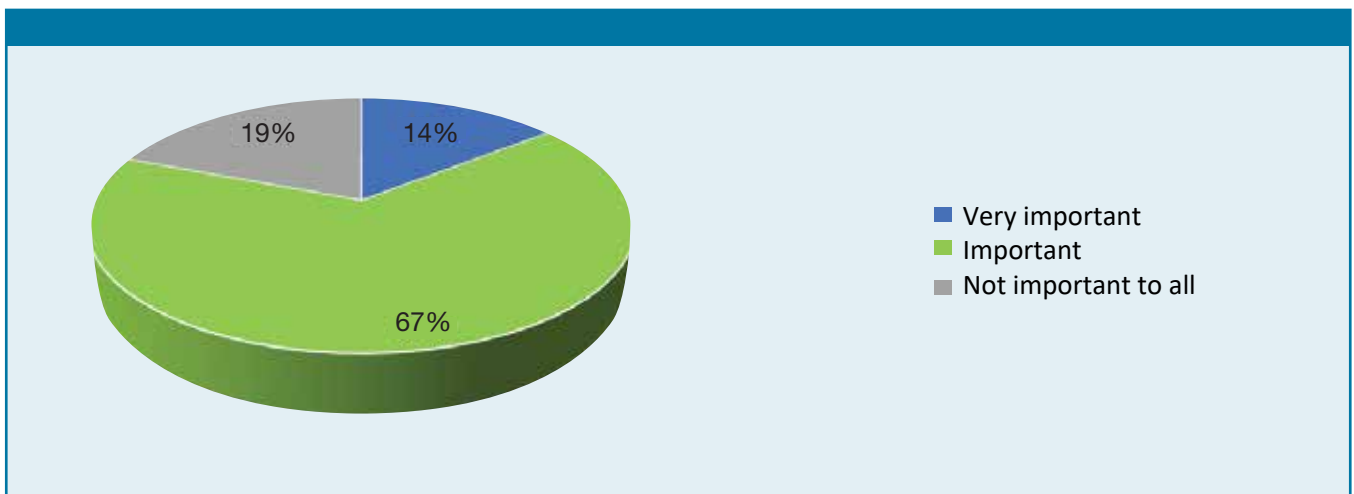


Figure 35 illustrates the importance of dowry for a marriage. Respondents who responded that dowry is important for marriage were asked about the level importance of dowry during marriage. It was revealed that 14% think dowry is highly important part of marriage, where majority (67%) responded that dowry was an important part of marriage, the importance level was not necessarily high but mediocre, and interestingly, 19% responded reported that dowry was not important for a marriage.

Figure 36: Opinion of respondents (in percentage) if dowry is not given

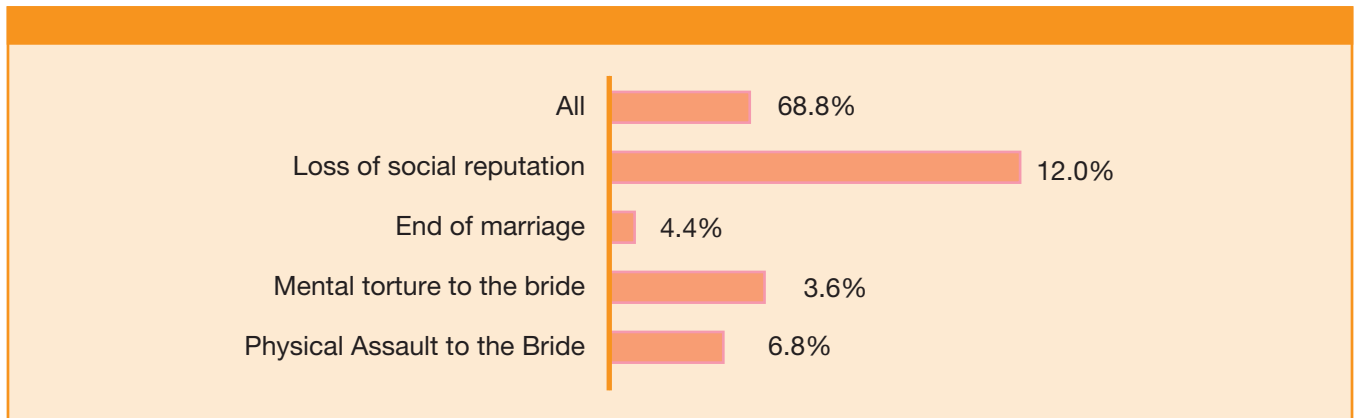
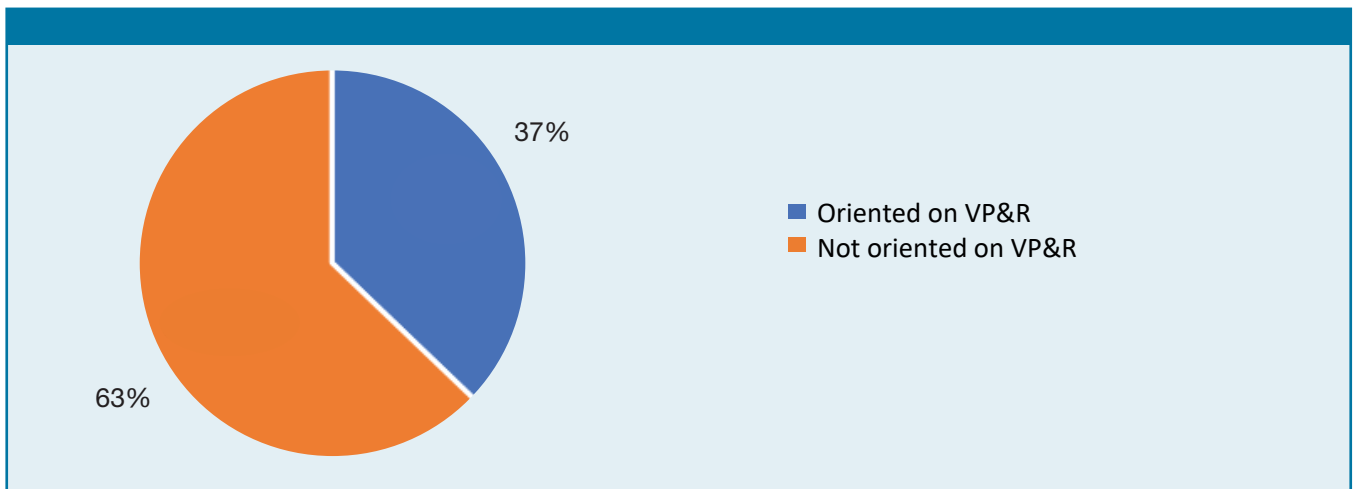


Figure 38 shows the opinion of respondents if dowry is not given in a marriage. The respondents who responded that dowry is an important part of marriage were asked again what could be happen if dowry is not given, their responds were - 6.8% think that physical assault could be happen to bride, 3.6% thinks that bride could face mental torture, 4.4% thinks not giving dowry can end a marriage, 12.0% think that there can be loss or reputation for bride’s family if dowry is not given and 68.8% thinks that all of these can happen at once if dowry is not given during marriage.

Figure 37: Knowledge on violence prevention and response



Figures 37 depicts about the status of orientation among the respondents on violence prevention and response. Among the respondents, 63% mentioned that they never had any kind of previous orientation on violence prevention and response while 37% got some kinds of orientation on violence prevention and response before this interview.

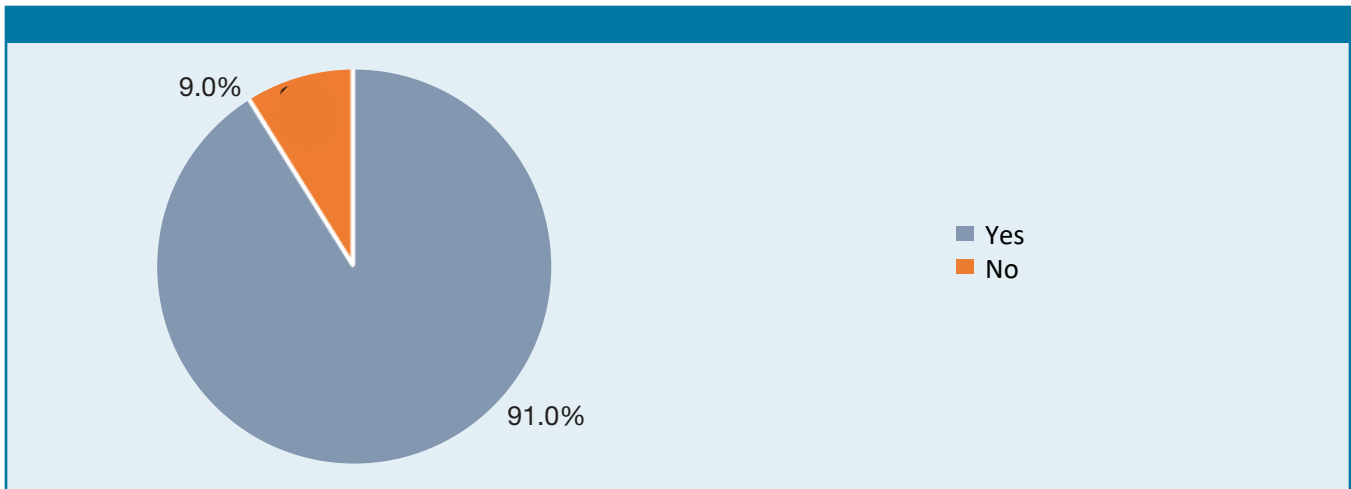
Figure 38: Intention for respondents for seeking help for violence in future

Figure 38 portrays the intention of respondents for seeking help in future if they face any violence. Interestingly, 91% respondents agreed that they would seek help in case of any violence if occur in future while 9% did not have intention to get any help.

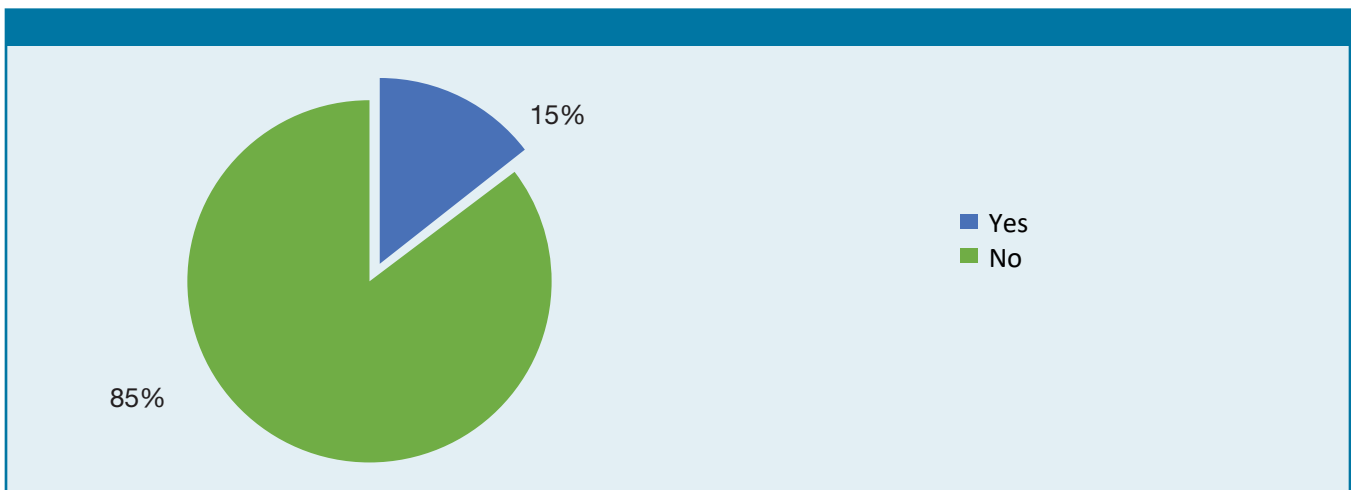
Figure 39: Awareness on Govt. Hotline number (109) for getting assistance after violence

Figure 39 articulates the awareness status of respondents on the government hotline number. Surprisingly, this was the matter of grief that 85% did not know about the hotline number (109) provided by Bangladesh Government for Violence prevention and response against women while only 15% know about this number.

CHAPTER 4

CONCLUSION AND RECOMMENDATION

4.1 Conclusion

Violence exists over the world since humankind began, before the idea of society came; looking back to history interprets that violence happened from people to people, one clan to another clan, one country to another country; inside home, within the society all the time. And, history also reveals that most of the times the origin of violence is Gender Based Violence (GBV) more specifically violence against women. These circumstances reflect similarly in Bangladesh; various publications, reports, case studies, researches have been revealed that Gender Based violence is prevailing in Bangladesh all the time both in rural and urban settings.

This baseline study findings also complement the existing literature regarding violence against women. In regular day to day life, violence was already prevalent where possibilities of violence increase during emergency. The cases of violence in the study area was identified through the case study sent by MCH center while the staff were working during disaster period. The baseline study was determined to find out the magnitude of violence in these identified areas following a predefined, standard social Research Methodology. Violence and discrimination are there in rural areas like Tala, Shatkhira or Sreefoltola, Khulna as well as in urban locality as Laalbag, Dhaka. Different forms of Gender based violence and discrimination like Child marriage, Dowry, Domestic Violence, Sexual Violence, Physical and mental health violence, Unwanted early pregnancy, End of education and work, food and nutrition deprivation, discrimination in decision making etc. are frequent in the communities those were selected for preexisting information collection from this VP&R project. Both the quantitative and qualitative results contemplated that violence prevention and response is an urgent timely requisite to address Gender Based Violence leading to achieving SDGs. This study concludes that violence prevention and response to be embedded uniquely for sustainable development. Finally, the study also articulated some important recommendations in order to reduce the prevalence of gender-based violence, which are given as follows.

4.2 Recommendations

The recommendations that were driven from the study were articulated as follows:

- Knowledge, attitude and practice on violence prevention and response among community people should be increased and continued through raising awareness
- Different types of community mobilization events, distribution of IEC materials, trainings, meetings and workshops using participatory approach should be applied for awareness raising and sensitization among community people and change agents.
- Awareness building is needed in the community regarding VP & R and GBV in form of health promotion and education.
- The community leaders should be oriented and sensitized regarding violence prevention and response.
- School children should be oriented on the bad effects of child marriage and dowry
- The community people should be introduced with the referral mechanisms regarding different kind of violence's, preventive measures and how to respond in their respective communities. The gap between community leaders and community people needs to be identified and addressed.
- Special initiatives should be taken specifically for the underprivileged women, younger and adult group to make them aware about Violence Prevention and Response.
- Capacity building within BDRCS is also important to address GBV in social and emergency setting. Further capacity building on GBV in normal and Emergency can be introduced.
- Local law enforcers like Union Parisad/Local Thana should be more active to provide legal and other support to the victims
- Violence Prevention and Response/GVB issue should be incorporated in emergency and other development programs
- Economic Empowerment Activities for female should be encouraged under any development program to reduce gender-based violence indirectly

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8. <https://guides.womenwin.org/gbv/conflict/context/what-is-gender-based-violence>
9. <https://www.dhakatribune.com/bangladesh/nation/2018/12/06/research-shows-66-bangladeshi-women-are-victims-of-domestic-violence>

Annex 1 Questionnaire

Baseline Questionnaire for VP & R Project

Interviewer explains the objectives, process and the rights of autonomy and confidentiality to the respondent, get her consent prior to interview

ID no:

Date and time of interview:

Name and Address of the Respondent:

Phone number:

Socio-demographic Information

SI No.	Question	Answer
1	Age of the Respondent: In years	
2	Religion:	<ol style="list-style-type: none"> 1. Islam 2. Hindu 3. Buddhist 4. Christian 5. Others (Please specify)
3	Education:	<ol style="list-style-type: none"> 1. No formal education 2. Can give signature only 3. Primary 4. Secondary (SSC/equivalent) 5. Higher secondary (HSC/equivalent) 6. Undergraduate/Diploma 7. Graduate 8. Post graduate and more
4	Occupation:	<ol style="list-style-type: none"> 1. Housewife 2. Govt Service 3. Non-Govt. Service 4. Teacher 5. Doctor 6. Nurse 7. Lawyer 8. Engineer 9. Business 10. Day labourer 11. Tailor 12. Others (please specify)

5	Marital Status:	<ol style="list-style-type: none"> 1. Unmarried 2. Married 3. Separated 4. Divorced 5. Widowed
8.1	Age of husband/partner (if any)	
8.2	Educational background of Husband (if any)	<ol style="list-style-type: none"> 1. No formal education 2. Can give signature only 3. Primary 4. Secondary (SSC/equivalent) 5. Higher secondary (HSC/equivalent) 6. Undergraduate/Diploma 7. Graduate 8. Post graduate and more
8.3	Occupation of husband	<ol style="list-style-type: none"> 1. Nothing 2. Govt Service 3. Non-Govt. Service 4. Teacher 5. Doctor 6. Nurse 7. Lawyer 8. Engineer 9. Business 10. Day labourer 11. Tailor 12. Others (please specify)
6	Number of female members in family	
7	Number of male members in family	
8	If there is any disabled person in the family?	<ol style="list-style-type: none"> 1. Yes 2. No
9	Personal monthly Income (If any)	
10	Monthly Family Income	
11	Monthly expenditure	
12	How old were you when you got married? (if ever married)	
13	How old were you when you got your first child? (if any)	

Information of Health seeking Behaviour and Nutrition		
14	Where do the family members seek healthcare?	<ol style="list-style-type: none"> 1. Govt. Hospital 2. Private clinics 3. HealthCare centres (UHC/Community clinics/other centres) 4. Village doctor 5. Traditional 6. Pharmacy 7. Others (Please Specify) 8. Do not have capability
14.1	Do you think that facility is far from your place?	<ol style="list-style-type: none"> 1. Yes 2. No
15	Was/is there any expecting/lactating mother in the family?	<ol style="list-style-type: none"> 1. Yes 2. No
15.1	Did/does the mother get proper access to healthcare facility (hospital/doctor/MCH) during her pregnancy?	<ol style="list-style-type: none"> 1. Yes 2. No
15.2	Where did/will be the child born?	<ol style="list-style-type: none"> 1. Home 2. BDRCS MCH centre 3. Govt. Hospital 4. Private clinics 5. Other HealthCare centres
15.3	If the child born/will in home, then what were the reasons for that?	<ol style="list-style-type: none"> 1. Family did not approve 2. Regular family practise 3. Conservative mindset 4. Hospital/MCH is not nearby (communication) 5. Financial inability 6. Others (describe)
15.4	Has the mother faced any issue regarding girl childbirth in the family?	<ol style="list-style-type: none"> 1. Yes 2. No
15.5	If yes, what are those issues?	<ol style="list-style-type: none"> 1. Intended to forced abortion 2. Social pressure 3. Demand for a boy child 4. Emotional violence to mother 5. Domestic violence to mother 6. Domestic violence to female child 7. Others (please specify)

16	Which food items were provided to the pregnant/lactating mothers?	<ol style="list-style-type: none"> 1. Eggs... 2. Milk... 3. Meat... 4. Fish... 5. Green leafy vegetables 6. Fruits... 7. None of those was provided
16.1	Did your family provide these food items regularly?	<ol style="list-style-type: none"> 1. Yes 2. No
16.2	Was the pregnant/lactating mother supported mentally and physically by family members?	<ol style="list-style-type: none"> 1. Yes 2. No
17	Who get the larger/bigger portion of any meal in the family?	<ol style="list-style-type: none"> 1. Head of the family only 2. Male members & children only 3. Head of the family and male members only 4. Female members & children only 5. Portion is equally distributed
Information of decision-making rights		
18	Who has the decision-making power in following sections?	
18.1	Who has the final say on decision making on food and clothes?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)
18.2	Who has the final say on decision making regarding health?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)
18.3	Who has the final say on decision making regarding large investment?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)
18.4	Who has the final say on decision making regarding Education?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)
18.5	Who has the final say on decision making regarding marriage of son/daughter?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)

18.6	Who has the final say on decision making regarding family planning?	<ol style="list-style-type: none"> 1. Myself 2. Husband 3. Both equally 4. Other family member (please specify)
19	Are you able to visit friends/close relatives without permission of your husband or other family members?	<ol style="list-style-type: none"> 1. Yes 2. No
20	Are you able to visit Health Centers without permission of your husband or other family members?	<ol style="list-style-type: none"> 1. Yes 2. No
21	Are you able to visit any association/organization or attend any community meeting without permission of your husband or other family members?	<ol style="list-style-type: none"> 1. Yes 2. No
Information on History of Violence and Response		
22	Have you ever experienced any violence ever in your life?	<ol style="list-style-type: none"> 1. Yes 2. No
22.1	If yes, what type of violence was it?	<ol style="list-style-type: none"> 1. Emotional 2. Physical Assault 3. Sexual 4. Economic 5. Others (please specify)
22.2	What was the causes of this violence?	<ol style="list-style-type: none"> 1. Financial 2. Dowry 3. Land 4. family related 5. Social insecurity 6. Addicted partner 7. Others (please specify)
22.3	What was the consequence of that violence?	<ol style="list-style-type: none"> 1. Psychosocial problems (fear/tension/depression) 2. Suicidal ideation 3. Attempted suicide 4. Physical problems 5. Reproductive health problems 6. Unwanted pregnancy 7. Sexually transmitted disease 8. Stopped education 9. Stopped working 10. Others (please specify)

22.4	Who was the perpetrator of those type of violence?	<ol style="list-style-type: none"> 1. Partner 2. Family member 3. Police 4. Teacher 5. Doctor 6. Neighbour 7. Others
22.5	Did you ever sought for any support when you faced violence?	<ol style="list-style-type: none"> 1. Yes 2. No
22.6	Did you got that support you sought for?	<ol style="list-style-type: none"> 1. Yes 2. No
22.7	If yes, what kind of support it was?	<ol style="list-style-type: none"> 1. Health (Hospitals, other healthcare facilities) 2. Legal (NGO, Police station, Court, UP, Community leaders, Upozilla Parishod) 3. PSS (Family, Friends, Colleagues, Teachers, Neighbours, Community leaders, NGO, BDRCS, Healthcare facilities, others)
22.8	Have you faced any barrier while seeking those support?	<ol style="list-style-type: none"> 1. No 2. More violence from family for asking support 3. No knowledge of where to get support 4. Financial inability to get the support 5. Local law and enforcement department did not cooperate 6. Social pressure 7. Scared about reputation 8. Further violence/harassment from the places where sought for support 9. Cannot go outside of home 10. Fear of husband
23	Have you ever been prohibited by your husband/family members from getting a job, going to work, trading or earning money?	<ol style="list-style-type: none"> 1. Yes 2. No
24	Have your husband/family member ever taken your earnings against your wish?	<ol style="list-style-type: none"> 1. Yes 2. No

25	Have your husband/family members ever thrown you out of house?	1. Yes 2. No
26	Do you think physical assaulting by husband is acceptable?	1. Yes 2. No
27	At what age, a boy should marry?	
28	At what age, a girl should marry?	
29	how important is dowry during marriage?	1. Very Important 2. Important 3. Not important at all.
29.1	What would happen if dowry is not given?	1. Physical violence to the bride 2. Emotional violence to the bride 3. Marriage would be broken 4. Bride would be sent back to father's house 5. Social reputation would be tarnished 6. Bride and her family might suffer from humiliation. 7. Others (please specify)
30	Have you ever received any kind of information/orientation on SGBV prevention?	1. Yes 2. No
31	Will you seek for support if there is any violence in future?	1. Yes 2. No
32	Do you know Bangladesh Govt. has a hotline number (109) for providing support for SGBV?	1. Yes 2. No
33	Do you have any suggestion for Violence Prevention and Response?	1. Yes 2. No
Suggestion (if any):		
Name and signature of the interviewer:		

*Note: This questionnaire was adopted and interviewed in its Bangla translated version with more explanation.

Annex 2 Project Profile

Violence Prevention & Response Project Pilot Phase II

Project at a glance:	
Country	Bangladesh.
Project title	Violence Prevention & Response Project
Beneficiaries	15,000 Households including Mother, Neonatal, Child and Adolescent 82,500 people (5.5 per family times 15,000)
Project duration	July 2018 – June 2019
Project location	5 MCH Centres from- (1 in Urban and 4 in rural context) Dhaka District : Jamila khatun MCH Center, Lalbag, Dhaka. Khulna District : Shreefoltola MCH Center, Khulna. Borishal District : Kajlakathi MCH Center, Borishal. Shatkhira District : Tetulia MCH Center, Tala, Shatkhira; and Horinogor MCH Center, Shaymnagar, Shatkhira.
Project Financed by	Australian Red Cross
Technical Support by	International Federation of Red Cross and Red Crescent Societies (IFRC)
Implemented by	Bangladesh Red Crescent Society (BDRCS).
Project Goal	Increased safety and well-being of women, men, girls and boys in 5 districts of Bangladesh.
Project Objectives	Outcome 1: BDRCS staff and volunteers have an increased understanding and capacity in violence prevention and response issues. Outcome 2: Target communities have an increased understanding of gender equality issues around violence prevention, response and child marriage. Outcome 3: Communities have increased Knowledge on VPR & ensuring rights and are seeking assistance from GO/NGOs
Priority approaches	<ul style="list-style-type: none"> ▪ Community and local government leaders get training on VPR so that they understand the rights of marginalized groups so that they can support the program and advocate for the rights of these people. Project will involve relevant government department and local government so that they provide legal support to those vulnerable groups in order to prevent and response to gender-based violence and improve the protection of vulnerable people. ▪ The project will document case of violence and share the relevant department to raise awareness and minimize incidence of violence ▪ The project will use the developed VPR materials for capacity development of change agents ▪ Project will develop linkage between government and beneficiaries so that beneficiaries get information and continued support from government

Project Activities

- Induction and Theory of Change Workshop for VPR Project
- TOT Training on VPR to Community Mid Wife, Red Crescent Youth & Centre Management Committee, Community Health Promoter (3 Days)
- VP&R Workshop for BDRCS departments (branch, CPP volunteers and external NGO representative working in GBV) to incorporate VP&R concept in resilience program
- Workshop on VPR for UP (1 day)
- Lessons learned workshop for Community health promoters, volunteers, unit RCY, NGO representatives and midwives who are implementing the project
- Document the existing situation on VPR in the communities (Baseline Survey)
- VPR Sessions at community/Household Visit
- Community Mobilization Event - Folk Song/Drama at school and community
- IEC/Behavior change communication materials including leaflet, poster, calendar

Annex 3: Photo Archive



CHPs in Tetulia MCH Center, Shatkhira for Data Collection Training.



Data Collection at a community household



Data Collection at Laalbag Jamila Khatun MCH Center surrounding areas

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Violence Prevention and Response Project Pilot Phase II

Health Department

Bangladesh Red Crescent Society (BDRCS)

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