MAY 2016

SITUATION ANALYSIS BRIEF

Adolescents in Bangladesh

Programmatic Approaches to Sexual and Reproductive Health Education and Services

There is a gap in knowledge and understanding of effective adolescent sexual and reproductive health (ASRH) programming in Bangladesh, especially programming at scale. Initiatives to address ASRH have been implemented at different times by both the Government of Bangladesh (GOB) and NGOs, but these activities have often been fragmented and are not well documented or evaluated, making it difficult to know what worked well and what did not. With a large and growing adolescent population, it is critical to identify, invest in, and accelerate the expansion of proven approaches to ASRH programming.

USAID FROM THE AMERICAN PEOPLE

Evidence

To most effectively address the sexual and reproductive health (SRH) needs of adolescents in Bangladesh, there is an urgent need to gain a deeper understanding of the myriad ASRH programs and interventions that have been implemented in the country (see **Box 1**). In order to make strategic investments in future ASRH programming and improve upon current programs, there is a need to understand which programmatic approaches can improve adolescents' knowledge of SRH issues and their access to and uptake of services, and to identify gaps in programming knowledge and practice. There is also a need to critically examine the evidence base for these programs to determine which interventions lack rigorous evidence of effectiveness and, more importantly, to identify and promote those that have been proven, through strong evidence, to effectively and efficiently deliver positive outcomes for adolescents. This will enable the evidence-based scale up of promising interventions, help minimize implementation of ineffective or duplicative efforts, and ensure efficient use of available resources.

This policy brief presents selected findings from a comprehensive review and analysis of ASRH programming in Bangladesh, carried out by the Population Council's Evidence Project, with financial support from USAID/Bangladesh, as part of a larger research initiative on "Improved Adolescent Sexual and Reproductive Health (ASRH) Outcomes in Bangladesh." The objective of the review was to identify programmatic and evidence gaps, as well as best practices, and support the development of effective, inclusive, and sustainable programs that can operate at scale. In close collaboration with the Ministry of Health and Family Welfare (MOHFW), Directorate General of Family Planning (DGFP), USAID, and national partners working in the field of ASRH, the Population Council and the Evidence Project seek to support the generation and synthesis of evidence on recent and ongoing ASRH programs and initiatives.

METHODS

Activities undertaken as part of this review included: identification of SRH programs in Bangladesh with a focus on adolescents, collection of relevant programmatic information, analysis of selected programs, field visits to current ASRH programs, and communication (including interviews) with ASRH program managers. The review was based on existing program documentation, including baseline reports, project briefs, project documentation of interventions, and final evaluation reports.

To determine the inclusion criteria for programs in the review, a series of meetings were held with key governmental, non-governmental, donor and development partner stakeholders. These included BRAC, BIED, BRAC School of Public Health, UNFPA, USAID, UNICEF, FPAB, Save the Children, CARE, Plan International, and icddr,b. Based on discussions at these meetings, programs were included in the review if they met the following criteria:

1. They were implemented between 2005 and 2015
2. They included young people ages 10-24 as target beneficiaries (adolescents 10-19 years old were the primary group of interest for this review, but 10-24 years was settled on for the inclusion criteria, for consistency with the broader age range of many programs)
3. They included some programmatic focus on SRH
4. They had some documentation of the mechanism of the intervention and monitoring and evaluation processes

Based on these criteria, **32 programs and interventions were identified and included** in this review. See **Table 3** on page 10 for a complete listing of programs.

BOX 1

WHAT DO WE MEAN BY "ASRH" PROGRAMS?

ASRH programs address the specific sexual and reproductive health needs of adolescents (10-19 year olds), as distinct from those of adults; some programs also include youth up to age 24. Programs may seek to raise awareness or increase knowledge of SRH among adolescents, or improve services for adolescents related to such issues as sexual health, reproductive health, maternal health, STI prevention and care, HIV/AIDS prevention and care, menstrual hygiene and management, family planning and menstrual regulation.

RESULTS

A. THEMATIC FOCUS AREA

This review explored the thematic focus areas of the 32 interventions identified, in particular examining the programs' specific focus on SRH and their coverage of adolescents and youth ages 10-24. Based on the programs included, this review reveals that:

- Approximately **two-thirds** of the programs (21 of 32) included SRH as a primary focus
- But **only half** of the programs (16 of 32) focused exclusively on adolescents ages 10-19
- **Only nine** programs (9 of 32) had both a primary focus on SRH and were exclusively focused on adolescents ages 10-19

The review also identified the following trends:

There is a lack of SRH programs that are exclusively focused on adolescents.

Although the SRH needs of adolescents are beginning to gain attention in Bangladesh, the review revealed that there is still a lack of SRH programs focused exclusively on the needs of adolescents. Of the 32 programs reviewed that had an SRH component, only 16 programs were exclusively targeted towards adolescents ages 10-19. The rest of the programs included adolescents not by design, but through their coverage of a wider age range of beneficiaries, e.g. women of reproductive age (15-49), and did not include interventions tailored towards adolescents' specific needs.

Adolescent-specific programming often includes SRH as a secondary component, strategically bundled with other interventions.

Due to institutional, policy, and social norm-related barriers, programs that focused exclusively on adolescents did not typically have a significant focus on SRH. When programming for adolescents included SRH-related components, they were typically a secondary focus, incorporated into other, more socially acceptable gender-related interventions such as child marriage and gender-based violence (GBV). Only nine programs of the 32 reviewed had both SRH as a primary focus and were exclusively focused on the 10-19-year-old age group. The bundling of SRH interventions with other, more acceptable interventions is strategic, however, allowing programs to address more sensitive and stigmatized topics - such as premarital sex and teenage pregnancy outside of marriage - that would otherwise be considered taboo in Bangladesh's conservative, religious culture.

ASRH programs focus predominantly on girls, with little specific attention to boys.

11 GIRL-ONLY PROGRAMS + **21** MIXED (BOYS AND GIRLS) PROGRAMS

The adolescent programs reviewed were disproportionately focused on girls, with very little programming for boys. Among the 32 programs reviewed, 11 programs focused exclusively on girls and the remaining 21 included both genders in their target group. None of the programs reviewed had an exclusive focus on adolescent boys. The focus on girls is understandable, given that inequitable gender norms and attitudes in Bangladesh result in significantly greater vulnerability for girls (such as child marriage, early pregnancy, maternal death, and so forth).

However, adolescent boys also face serious challenges in their transition to adulthood, particularly regarding SRH issues. Expanding the number of programs that address adolescent boys' SRH needs, alone or in conjunction with programming for girls, would contribute to improving ASRH outcomes overall in the country.

Younger adolescents and unmarried girls are neglected in programming.

Due to the same barriers mentioned above, certain segments of the adolescent population face even more stringent barriers in addressing their SRH needs. Married girls, due to the social acceptability of sexual union and child bearing inside marriage, are able to seek and receive a host of SRH, maternal health, and family planning services, irrespective of their age. However, their unmarried counterparts are typically barred from receiving the same, as a matter of policy and practice. Unmarried adolescents are, at best, only able to receive information on SRH and related issues but not services. The standard SRH packages supported by the government for unmarried and married adolescents are shown in **Tables 1 & 2** below; NGO clinics offer all their services (including contraception and menstrual regulation) to all adolescents, regardless of marital status.

TABLES 1 & 2: STANDARD SRH INFORMATION & SERVICES PACKAGE FOR ADOLESCENTS FROM GOVERNMENT HEALTH FACILITIES

INFORMATION
Physical and mental changes during puberty
Food and nutrition
Tetanus and other vaccines
General and menstrual hygiene
Early marriage and reproductive health
Birth control
Violence against adolescent girls and boys
Drug addiction

SERVICES		
Service Type	Married	Unmarried
Treatments for sexual and reproductive tract infections	✓	✓
Menstrual problems and management	✓	✓
Treating anemia and distribute iron and folic acid supplements	✓	✓
Tetanus vaccine	✓	✓
Pregnancy related services	✓	
Menstrual regulation	✓	
Family planning methods	✓	
Post abortive care	✓	

The review also found a lack of tailored, age-appropriate SRH programming for younger adolescents (ages 10 to 14), an important and vulnerable group. Only two ("Creating an enabling environment for young people to claim and access their sexual and reproductive health rights in Bangladesh" and Generation Breakthrough) of the 32 programs reviewed had a tailored strategy for 10-14-year-olds.

Bundling SRH interventions for adolescents with other, more socially acceptable interventions was frequently employed by programs as a strategy to ensure the provision of services to younger adolescents and unmarried adolescents, many of whom would otherwise have no access to ASRH services.

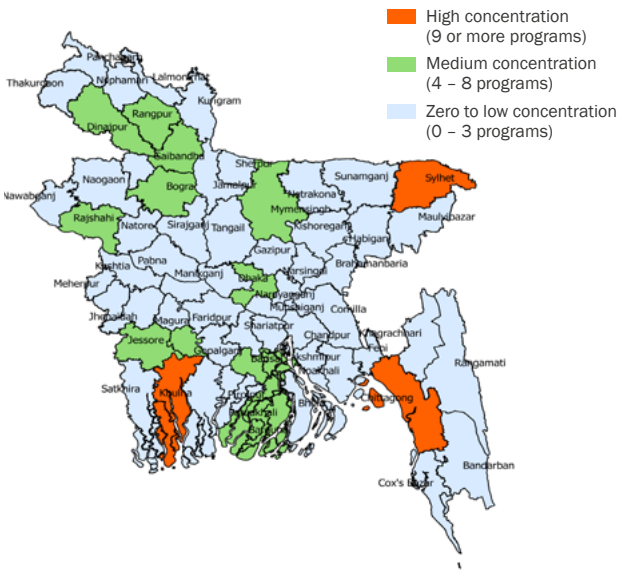
B. GEOGRAPHIC COVERAGE AND PROGRAM DURATION

I. GEOGRAPHIC COVERAGE

This review found uneven geographic coverage of ASRH programs across Bangladesh. As illustrated in **Map 1,** programs were concentrated in a few specific districts (Khulna, Sylhet, and Chittagong, where this review identified nine or more programs implemented), while other districts have seen few or no programs at all. The concentration of programs in certain districts may be a result of implementers choosing to work in areas where they have long-standing experience or where they have identified need. The concentration of ASRH programs was also found to be higher in rural areas compared to urban areas. Urban slum areas, which comprise a significant and vulnerable segment of the population in Bangladesh, have been particularly underserved, with only two identified programs (SAFE and SHOKHI) implemented in these areas.

The low concentration of programming across much of Bangladesh suggests a need to expand ASRH programs to underserved areas, using evidence to determine priority areas for programming. Careful analyses of national indicators and documentation of ASRH needs will help focus future investments on geographical areas and regions where the needs are greatest.

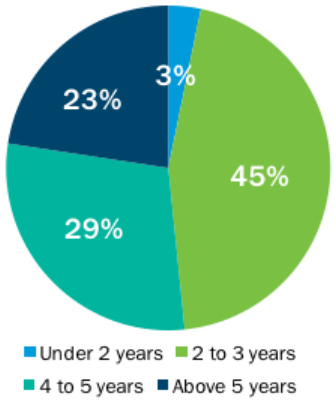
MAP 1: DISTRICTS BY LEVEL OF PROGRAM COVERAGE



II. PROGRAM DURATION

The review found significant variation in program duration (**Figure 1**). More than half of the programs were implemented for more than three years (29 percent for 4-5 years and 23 percent for more than 5 years), while slightly less than half (45 percent) were implemented for two or three years. The finding of longer interventions and programs is encouraging, as longer programs enable interventions to reach optimal effectiveness and generate useful lessons for evidence-based programming and planning. Among programs that lasted more than five years, a few select programs have been run continuously for over two decades, although the ASRH components of some were phased in more recently as the SRH needs of adolescents have gained greater attention.

FIGURE 1: DISTRIBUTION OF PROGRAMS BY DURATION



C. ASRH PROGRAMMING APPROACHES

While there are many different types of ASRH programs, this analysis found two approaches to be most common in Bangladesh: 1) awareness raising and 2) service delivery. All of the programs reviewed included awareness raising components, while fewer (though still a significant number) included service delivery.

I. AWARENESS RAISING APPROACH

This review found awareness raising and knowledge building to be the most common ASRH strategy. All of the reviewed programs employed this approach to bring about positive change in adolescents' knowledge, attitudes, beliefs, and behavior regarding SRH, and to increase their demand for SRH services. Different programs adopted different models of awareness raising, including community-based, school-based, and peer-led models, with community-based and peer-led models being the most commonly used.

Community-based model

Community-based models for awareness raising have been a mainstay in broader development programming for decades. These models were used in some of the earliest SRH programs in Bangladesh (such as AVIZAN and

APON) and continue to be a common approach. In recent years, community-based models have been extensively employed in programs targeting adolescents, including in ASRH programming. Nearly all programs considered in this review utilized some form of a community-based model to raise awareness about SRH issues among adolescents, often in combination with school-based or health facility based-models, or with media campaigns.

Community-based models have been popular in Bangladesh, as elsewhere around the world, because of their expansive reach. In community-based models, adolescents receive SRH information, and in some instances services, alongside other social services, combined with age-appropriate recreational activities. Adolescents are reached through community-based awareness raising programs and sessions, typically organized in community common spaces such as village squares, courtyards or playgrounds, or through "safe spaces" programs that are implemented through adolescent clubs, youth centers or "fun" centers.

Despite their popularity, community-based models for ASRH also have their challenges. Results from this review suggest that the most vulnerable adolescents with the most pressing SRH needs — younger, married, or out of school adolescents — may be missed by community-based awareness raising programs, as they are typically not targeted towards these vulnerable groups, but instead designed to reach adolescents in general. The review found that these programs typically benefited relatively advantaged adolescents and youth (older, unmarried, literate, and in school), failing to adequately reach married, younger, and out of school adolescents, who are at an elevated risk. Results also suggest that community-based models are difficult to implement in urban settings, particularly in slum settings, where communities lack a high degree of social cohesiveness and stability and are highly mobile.

Peer model

Alongside community-based models, peer education is another commonly employed model for awareness raising in ASRH programming in Bangladesh: out of the 32 programs reviewed, two-thirds employed peer-led models for awareness raising. Of the nine ASRH-focused programs, seven employed a peer educator model, in combination with other interventions, in particular with community-based approaches.

Peer educators are generally volunteers from the same or slightly older age range as the target population who are trained to offer SRH information and counseling to their peers. Beneficiaries of SRH peer model programs receive education and counseling on ASRH issues, referrals to youth friendly clinics, and informational materials.

Peer models have the benefit of being relatively inexpensive and easy to implement. Peer models are also popular because of the perception that peers can tap into existing social networks, have more regular and repeated interaction with adolescents – rather than being limited to formal sessions – and that adolescents may be more comfortable talking to peers about culturally sensitive issues related to sexuality and SRH that are typically not discussed openly in the conservative Bangladeshi society.

In spite of the popularity of this model, there is limited evidence for the effectiveness of peer education. Programs that employ this model should examine the evidence base, carefully consider the utility of this approach, and apply rigorous monitoring and evaluation standards to peer education components to ensure the effectiveness of these programs in delivering positive impacts for adolescents.

School-based model

School-based programs are relatively new in the landscape of ASRH programs in Bangladesh and have not been extensively used in programming; only five programs, among which four are currently active, were identified that included a structured school-based component that addressed SRH. School-based ASRH programs seek to increase adolescents' awareness, knowledge, and understanding of SRH issues through programs and sessions implemented on school premises, and built into students' schedules. They also involve active participation from teachers and school management.

BOX 2

TRADE-OFFS BETWEEN COMMUNITY-BASED AND SCHOOL-BASED APPROACHES

One of the programs reviewed for this study (ARSHI-ITSPLEY) shed some interesting light on the relative advantages and disadvantages of school-based models and community-based models. The comparison showed that recruitment and participation was better in the school-based models, compared to community-based models. However, community-based models generated greater enthusiasm and openness among participants, compared with adolescents who were reached by a school-based model. Since teachers may not feel prepared or comfortable addressing culturally-sensitive ASRH issues, community-based models may also be a more feasible channel for sharing information and discussing those topics than schools.

School-based models have the advantage of reaching large numbers of adolescents at once and fostering strong sustained participation, since sessions are held as part of the regular school day and school sessions. Additionally, involving teachers increases the importance and legitimacy of ASRH issues in the perception of adolescents, their parents, and other gatekeepers.

As school-based models for awareness raising are new in the field of ASRH programs in Bangladesh, less is known about the impact of this model on ASRH outcomes. However, our review revealed that there may be some significant challenges to effectively implementing school-based models for ASRH in Bangladesh, particularly considering the complexity of coordinating with and the barriers in obtaining approval on raising awareness on ASRH issues from school management committees and the Ministry of Education, as these topics remain sensitive in the conservative cultural context. School-based programs are also typically unable to include service delivery or referral to health services.

Most significantly, teachers may not be prepared to effectively implement school-based ASRH programming. In 2012, the government's National Curriculum and Textbook Board (NCTB) introduced content on Adolescence and Reproductive Health for the curricula standards of classes 6 to 10. Although not covered in great detail, the inclusion of key ASRH topics could have been an opening for teachers, parents and adolescents to talk about this issue. Unfortunately, this curriculum is not being implemented due to teachers' reluctance to teach these topics in the classroom. No specific research has been done on the effectiveness and implementation of the national SRH curriculum, but a repeated theme in informal communication with teachers and program managers is that students are asked to read these chapters on their own, as teachers are not comfortable discussing topics that are perceived as sensitive. For a school curriculum intervention to be effective, more sensitization, training, and support for teachers will be required.

Further, school outreach models, which are distinct from structured school-based programs, are increasingly being implemented as part of community-based awareness raising models. The review suggests that the scope and impact of school outreach impacts may be limited. This is particularly true as the implementation and planning of school outreach programs, unlike structured school programs, have been uneven or inadequate.

As the school-based model is increasingly implemented, it is critical that future programs invest in building a strong evidence-based approach to applying this model through the adoption of strong research designs and rigorous monitoring and evaluation.

Community Mobilization

In Bangladesh, the community mobilization approach has also been extensively used in ASRH programming, typically in conjunction with other awareness raising approaches, including the three described above. In this approach, the intervention targets gatekeepers and decision-makers instead of the adolescents themselves. These interventions work to sensitize these key stakeholders on SRH issues and their importance for young people in the community, in particular to gain their acceptance to implement SRH programming for adolescents. Typically, parents, community leaders, religious teachers and opinion leaders, among others, are the targeted beneficiaries of community mobilization programs. In the conservative Bangladeshi societal context, these gatekeepers and their endorsement of programs are critical for their success. Elements of community mobilization were found in all 32 programs reviewed.

> "Community mobilization includes sensitizing key adult gatekeepers to ASRH issues."

II. SERVICE DELIVERY APPROACH

The second major approach utilized in ASRH programming in Bangladesh was service delivery. Of the 32 programs included in this review, 19 programs had service delivery components in different forms. The service delivery approach is implemented through two modalities: clinical and non-clinical services. A majority of the 19 programs that utilized the service delivery approach implemented both.

Clinical services include services where adolescents can speak to and meet with medical professionals in person (e.g. a doctor, nurse, or paramedic), receive diagnoses, testing services, prescriptions, or get contraceptives. Non-clinical services comprise the provision of SRH information and counseling, but do not include medical interventions. Clinical services are often implemented in conjunction with programs that combine SRH and family planning (FP) or maternal health services, including adolescents only as a subset of a broader and older group of target beneficiaries (e.g. women of reproductive age). Non-clinical services are delivered either in person at adolescent friendly centers or via tele counseling (through a toll free hotline).

Although a number of programs are implementing a service delivery approach, SRH service delivery for adolescents in Bangladesh is extremely complex and faces barriers and challenges due to conservative societal norms and the corresponding policy environment. This review

revealed that although adolescents have opportunities to access clinical services at health facilities, a large segment of them, mostly those who are unmarried, are not inclined to do so. Generally, non-clinical services were far more likely to be utilized by unmarried adolescents than clinical services.

Both supply and demand side factors are responsible for low utilization of clinical ASRH services. On the supply side, SRH service delivery is still primarily limited to married women, as health facilities are designed to provide antenatal checkups, delivery, and family planning services. Thus, as a matter of national policy of the Government of Bangladesh, as well as a function of religious and societal norms, the provision of SRH services (including contraceptives or STI services) for adolescents remains limited only to married adolescents, without any targeted clinical services available to unmarried adolescents. On the demand side, communities generally view health facilities as "family planning clinics," and the significant stigma associated with unmarried adolescents seeking such services creates a major deterrent for adolescents, particularly those who are unmarried, from visiting these centers. Similarly, most adolescents were found to consider even mainstream primary healthcare services unacceptable, particularly because of the perceived lack of respect, privacy and confidentiality and the fear of stigma, discrimination and the imposition of moral values by the healthcare provider.

However, initiatives to address some of these challenges have begun to be implemented in service delivery approaches. On clinical service delivery, the introduction of Adolescent Friendly Health Centers by the government will likely create improved access to both high quality services and information on SRH targeted towards the specific needs of adolescents (see **Box 3**). On non-clinical services, small scale but earnest efforts to provide SRH information and counseling to adolescents through youth centers by posting counselors at the center, or through safe space programs that are able to refer to facilities that are capable of delivering clinical services, are increasingly being utilized. However, the reach of these initiatives, as well as the quality of programs and capacity of counselors and staff trained to provide these non-clinical services have remained limited.

Irrespective of whether services were clinical or non-clinical, the review revealed that there is a significant lack of approaches that addressed a nexus of issues around SRH, adolescent mental health, substance abuse or the use of

BOX 3

ADOLESCENT FRIENDLY HEALTH CENTERS (AFHCS)

AFHCs are being created at ten government facilities (five Mother and Child Welfare Centers and five Union Health and Family Welfare Centers) in five districts (Sirajganj, Cox's Bazar, Patuakhali, Moulovibazar and Thakurgaon). The AFHCs are intended to meet the specific SRH needs of adolescents as a vulnerable group, with a focus on improving access to SRH information and counseling, and selected clinical services. The government plans to expand these AFHC's to other districts. Although there is some evidence in the global literature that AFHCs have not been effective, particularly due to implementation challenges, this must be considered in relation to the particular programmatic structure and country context. In Bangladesh, rather than being standalone facilities, AFHCs are built as parts of existing facilities where women and men seek healthcare, which may reduce the stigma and other barriers adolescents – especially unmarried girls – face when seeking SRH information. The government's investment in AFHCs signifies a recognition that in the Bangladeshi context, AFHCs are uniquely positioned to fill a critical gap in service provision by delivering information and services to adolescents, for whom SRH information and services are not readily available. To inform this investment and guide future expansion of AFHCs, the Evidence Project/ Population Council is assessing implementation challenges and successes of the AFHC initiative.

psychosocial counseling approaches. Similarly, the policy environment also remains strongly in favor of the delivery of clinical SRH services only to married adolescents, with limited likelihood for change.

PROGRAMMATIC CHALLENGES

Lack of coordination between stakeholders and collaboration with the government.

The programs identified in the review were nearly universally implemented by NGOs or research organizations. With the exception of one program in which the government was extensively involved, collaboration or coordination between ASRH program implementers and the government was limited. Creating opportunities for increased collaboration between the various implementing NGOs and stakeholders working in ASRH and the Government of Bangladesh is critical for the advancement and sustainability of ASRH programs. Moreover, the government is positioned to promote coordination among implementing organizations to avoid duplication and inefficiency and support creativity and innovation.

Limited use of innovative, non-traditional and age-appropriate interventions in ASRH programming.

Non-traditional approaches, such as sports-based interventions, the use of Information and Communication Technology (ICT), or game-based or interactive interventions have been used around the world to work with adolescents, including in SRH programming. However, these approaches are underutilized in Bangladesh, and our review identified a strong reliance on traditional approaches such as peer-education or community-based awareness raising programs. These approaches may also be important entry points for young adolescents ages 10-14. Other interventions such as those that employ psychosocial counseling or mental health counseling or that involves parents were also rarely observed.

> "...our review identified a strong reliance on traditional approaches such as peer-education or community-based awareness raising programs."

Limited rigorous evaluation and documentation of what works.

Of 32 reviewed programs, only three programs employed rigorous evaluation methodologies such as a randomized controlled trial or a quasi-experimental design (BALIKA, SAFE, and Link Up) to determine the impact and effectiveness of programs. Although many programs have done baseline assessments, they have not conducted rigorous impact evaluations. The majority of the programs used qualitative data to highlight success stories, but the inability to assess the impact of the interventions remains an inherent weakness of qualitative studies. There is little evidence that program documentation is based on monitoring data. Moreover, the implementation process and lessons learned are rarely documented. Given that rigorous research and evaluation in this field is limited, it is not yet possible to broadly define ASRH "Best Practices," which require strong evidence of a program's ability to deliver significant positive outcomes for adolescents. This mirrors the situation globally, as rigorous evidence on programming for ASRH has been limited and mixed when it does exist[1]. The three rigorously evaluated programs noted above, the results of which have shown promising positive results, are paving the way for identification of best practices in Bangladesh. However, a critical mass of programs must be rigorously evaluated and documented before any best practices can be validated and replicated or scaled up.

RECOMMENDED ACTIONS

Based on the review of 32 programs, this review identified future actions that should be prioritized to develop, refine or improve ARSH programming in Bangladesh.

Employ multifaceted programs, combining SRH with diverse interventions to enhance access to information and services.

Although multifaceted programs are increasingly being employed in Bangladesh, they are still not the norm, and must be promoted. This review suggests that multifaceted programs tend to be more inclusive and successful in addressing sensitive ASRH topics in the context of Bangladesh. Multifaceted programs enable the combination of such culturally sensitive issues with more acceptable themes and program approaches that target livelihoods, empowerment, maternal health or child marriage and to circumvent cultural and societal barriers.

Promising results are emerging from recent ASRH-focused programs that have been implemented employing a diverse set of interventions, including utilizing health and legal sectors, employing innovative use of ICT and mass media, and adolescent friendly channels to address issues as diverse as gender-based violence, improving SRH knowledge and practices, and preventing child marriage. Employing such multifaceted programs also enables partnerships that can leverage the comparative advantages and strengths of implementing partners, and encourage coordination and camaraderie in a field that is crowded, competitive and prone to duplication of effort.

Expand the number of interventions that specifically target younger adolescents, unmarried girls, and underserved groups such as boys and urban adolescents.

There is a need to expand the focus of ASRH interventions to cover several underserved groups of adolescents. The review revealed that younger adolescents (10-14 year olds), who are particularly vulnerable, are not yet recipients of targeted efforts. Similarly, unmarried adolescents face significant barriers in accessing SRH services or family planning because of societal taboos associated with pre-marital sex. Furthermore, the review identified a lack of interventions, beyond a few exceptions, targeting urban adolescents or boys exclusively, despite a global ASRH literature identifying their vulnerabilities. Efforts to deliver information, services, and support for these vulnerable groups must be strengthened, including through policy initiatives (e.g. prioritization of underserved groups in the National Plan of Action for Adolescents) or through the integration of diverse approaches to address the needs of these underserved populations.

Encourage age-appropriate intervention design, through innovative and tested approaches, to address underrepresented needs of adolescents.

The review revealed a strong preference for traditional approaches in ASRH programming in Bangladesh, heavily dependent on awareness raising through community based models and with a strong reliance on peer-led programs, despite a lack of strong evidence globally that attests to their effectiveness. Although some interventions have begun to utilize sports, ICT, and increasingly participatory and interactive approaches to reach adolescents, including in SRH programming, the adoption of these approaches is in its infancy. Age-appropriate and innovative interventions for adolescents, particularly ages 10-14 years old, including utilizing story-telling, art-centric and psychosocial approaches, the use of interactive, ICT-based curricula and life skills development, or sports-based programming for young adolescents need to be further encouraged, funded, implemented, and tested for their effectiveness.

Strengthen the rigor of monitoring, evaluation and research designs to evaluate current interventions and create a culture of evidence-based programming and policymaking.

There is a dearth of strong evidence and documentation on whether ASRH programs in Bangladesh work, are cost effective, or have a positive impact on important adolescent outcomes. For example, although global evidence does not indicate that peer-led models demonstrate significant impact to beneficiaries, this model is still frequently used in Bangladesh. Programmers should examine existing evidence, through a survey of the global literature, before designing or implementing interventions, to ensure that programs are based on the strongest available evidence.

A culture of generating and utilizing rigorous evidence for program design, refinement, and scale up must be fostered. Although two randomized control trial evaluations identified in the review – among the largest RCT evaluations of their kind in the world – are encouraging and indicate the capability in Bangladesh to conduct studies with such rigor, their resource intensiveness make them difficult to implement for most constrained organizations. A stronger emphasis must be placed on cost-effective data collection, developing and applying strong but easy-to-use monitoring systems, and the utilization of analysis tools that deliver results that can be used to improve current programs. Program evaluations should ensure that interventions are allowed to run for sufficient periods of time, allowing for full exposure of beneficiaries to the program and for more robust evaluations. The Government of Bangladesh, donors, and implementing partners must demand a higher standard for evidence, so that they have the information necessary to make evidence-based policy and program decisions.

Support and provide continuity to the critical role of the Government of Bangladesh in leading the ASRH field.

Despite the myriad implementing organizations and donors in the field of ASRH in Bangladesh, the review revealed the critical role the Government of Bangladesh continues to play in ASRH policymaking and programming in the country. The government plays a singular role in enacting policies and programs that facilitate appropriate programming and service delivery targeted towards adolescents. This includes its stewardship to the National Plan of Action on Adolescents and through initiatives such as the Adolescent Friendly Health Corners at government health centers. Support and technical assistance to these initiatives, as well as providing continuous and sustainable support to forums such as the National ASRH Networking Forum, which plays a critical coordinating role in bringing together various stakeholders in the field to share information and learn from each other, is essential to the success of programs. The government can lead the way in providing sustained leadership in coordinating partners to avoid duplication of effort and fragmented programming. Similarly, implementing partners and stakeholders should seek collaborations with the government to implement clinical and non-clinical services targeted towards adolescents through the government's service delivery network as well as seek collaboration among each other to ensure the most efficient use of resources and comparative advantage of expertise.

TABLE 3: LIST OF IDENTIFIED PROGRAMS AND INTERVENTIONS

	Intervention	*Year*	*Implementing Organization*	*Target Group*
1	**APON** *The Adolescent Peer Organized Network*	1998 to date	BRAC	Adolescent girls aged between 10- 19 years in school and out of school; parents
2	**ASHA** *Addressing unmet need of SRHR for adolescents and youth through creating awareness in selected area of Bangladesh*	2014 - 2016	RHSTEP	Young people aged 10-24 years
3	**ARSHI- ITSPLEY** *The Innovation through Sport: Promoting Leaders, Empowering Youth project*	2009 - 2012	CARE Bangladesh	Adolescent boys and girls
4	**ASRHR** *Adolescent Sexual and Reproductive Health Rights project in Disaster Prone Areas of Bangladesh*	2011 - 2013	Plan Bangladesh in partnership with South Asia Partnership (SAP) Bangladesh	Adolescents; parents; local government representatives; school teachers; religious leaders; local health service providers
5	**ASRYA** *Access to Safe MR and Reproductive Health for Youths and Adolescents*	2014 - 2016	RHSTEP	Young people aged 10-24 years
6	**AVIZAN** *Acceptance, Valuing, Information, Zero Tolerance, Advocacy, and Networking to promote adolescent sexual and reproductive health and rights*	1980 to date	FPAB	Young people aged 10-24 years
7	**BALIKA** *Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents*	2012 - 2016	The Population Council, PSTC, CIDIN & mPower	Adolescent girls aged 12-18 years
8	**Creating an enabling environment for young people to claim and access their sexual and reproductive health rights in Bangladesh**	2015 - 2019	Plan International Bangladesh, Marie Stopes Bangladesh, SAP, Bangladesh, Young Power in Social Action	Young people aged 10-24 years in three groups: 10-14, 15-19, 20-24; two groups married and unmarried
9	**GOAL: BYWLTS**	2013 - 2015	BRAC	Adolescent girls aged 11 -18 years both in school and out of school
10	**Generation Breakthrough**	2012 - 2016	Plan International Bangladesh, UNFPA, MOE, MOWCA, CWFD, BBC Action Media	Adolescent boys and girls aged 10-19 years both n school and out of school
11	**IMAGE**	2014 - 2016	Terre des Hommes Foundation, SKS Foundation, Pollisree	Married adolescent girls (aged under 18)
12	**Improve Youth Friendly Services (DANIDA A+) Project**	2011 - 2012	FPAB	Young people aged 10-24 years
13	**Kaishar** *Adolescents reproductive and sexual health program*	2003 - 2008	Save the Children Bangladesh	Adolescents aged 10-19 years
14	**Kishoree Kontha**	2006 - 2009	USAID	Adolescent girls aged 10-19 years
15	**Kishori Abhijan** *Adolescent Empowerment Project*	1st phase 2001 - 2005 2nd phase 2006 - 2010	BRAC, CMES	Adolescents girls aged 10-19 years
16	**Link Up**	2013 - 2015	Population Council, HASAB, Marie Stopes International Bangladesh (MSB)	Young boys and girls aged 10- 24 years

	Intervention	Year	Implementing Organization	Target Group
17	**Nirapod** *Saving Women from Unwanted Pregnancy*	2012 - 2015	Marie Stopes Bangladesh, Bangladesh Association for the Prevention of Septic Abortion (BAPSA), Phulki and Shushilan	Women, men, adolescents and garment factory workers
18	**P-SAFE** *Promoting SRHR and Adolescent Friendly Environment*	2011 - 2013	FPAB	Young girls and boys aged 10-24 years both in school and out of school
19	**PHR** *Protecting Human Rights*	2011 - 2016	Plan International Bangladesh, The Bangladesh National Women Lawyers' Association (BNWLA)	Women and children
20	**RHIYA** *Reproductive Health Initiative for youth in Asia*	2003 - 2006	BDRCS, CWFD, BWHC, FPAB, MSB, NM, USS, YPSA, Save the Children-UK in partnership with SOLIDARITY	Young people aged 10-24 years
21	**RSHP** *Reproductive & Sexual Health Program at rural, semi-urban and urban areas*	1981 to date	Bangladesh Women's Health Coalition (BWHC)	Women, children & adolescent boys and girls
22	**SAFE** *Growing Up Safe and Healthy*	2011 - 2014	ICDDR, B, Population Council, Marie Stopes, BLAST, We Can Campaign and NariMatiree	Adolescent girls and young women aged 10-29 years
23	**Sexual and Reproductive Health and Rights Program focusing on safe MR and reduction of unsafe MR in Bangladesh**	1st phase 2010 - 2014 2nd phase 2015 to date	RHSTEP	People aged 10-49 years, Special focus: 10-19 years
24	**Shokhi** *Narir Sahstho, Odhikar o Icchapuron*	2013 - 2017	BLAST, Bangladesh Women's Health Coalition (BWHC) and Marie Stopes (MSB), We Can Alliance	Women and adolescent girls working in the garment and domestic sectors
25	**Sishuder Jonno Program** *Adolescent Development Component*	2008 to date	Save the Children	Adolescents girls and boys aged 10-19 years both in school and out of school
26	**SRHR-E** *SRHR Education Bangladesh-Break the spiral of silence*	2012 - 2014	BRAC, BNPS CAMPE, FPAB and HASAB	Adolescent boys and girls aged 11-19 years; Secondary target group: 50 potentially opposing political leaders; 15 leading journalists
27	**SSCOPE**	2012 to date	BRAC-IED	Adolescents both girls and boys aged 10-19 years
28	**Strengthening Adolescent Reproductive Health in Bangladesh**	2008 - 2012	Plan Bangladesh, YPSA (Young Power in Social Action), LAMB, CWFD, PSTC, Radda MCH Centre, DSK, MSM	Adolescent boys and girls aged 10-19 years
29	**Tanisha** *Improving income and advancing social identity of rural adolescent girls*	2011 - 2013	Save the Children USA	Extremely poor adolescent girls
30	**Tipping Point**	2013 - 2017	CARE Bangladesh	Adolescents aged under 18 years both in school and out of school
31	**UBR** *Unite for Body Rights*	2011 - 2015	FPAB, RH-STEP, PSTC, DSK and Christian Hospital Chandraghona	Married and unmarried girls aged 10-24 years; women aged 15-49 years; poor people
32	**USAID DFID NGO Health Service Delivery Project**	2013 - 2014	NHSDP	Young people aged 15-25 years

ENDNOTES

(1) Hindin, M.J., and A.O. Fatusi (2009). Adolescent Sexual and Reproductive Health in Developing Countries: An Overview of Trends and Interventions. International Perspectives on Sexual and Reproductive Health. Vol 35. No. 2: 58-62

THE EVIDENCE PROJECT

Population Council
House #15B, Road #13
Gulshan, Dhaka 1212
tel: +880.2.984.2276
evidenceproject.popcouncil.org

CONTRIBUTORS

Sigma Ainul
Ashish Bajracharya
Kate Gilles
Karen Hardee
Laura Reichenbach
Ubaidur Rob
Anneka Van Scoyoc

USAID FROM THE AMERICAN PEOPLE

The Evidence Project is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-13-00087. The contents of this document are the sole responsibility of the Evidence Project and Population Council and do not necessarily reflect the views of USAID or the United States Government.

Evidence

The Evidence Project uses implementation science—the strategic generation, translation, and use of evidence—to strengthen and scale up family planning and reproductive health programs to reduce unintended pregnancies worldwide. The Evidence Project is led by the Population Council in partnership with INDEPTH Network, International Planned Parenthood Federation, PATH, Population Reference Bureau, and a University Research Network.

Suggested Citation: Ainul, Sigma, Ashish Bajracharya, and Laura Reichenbach. May 2016 “Adolescents in Bangladesh: Programmatic Approaches to Sexual and Reproductive Health Education and Services,” Situation Analysis Brief. Dhaka, Bangladesh: Population Council, Evidence Project.

Photo credit on cover page: ©2016 Ashish Bajracharya