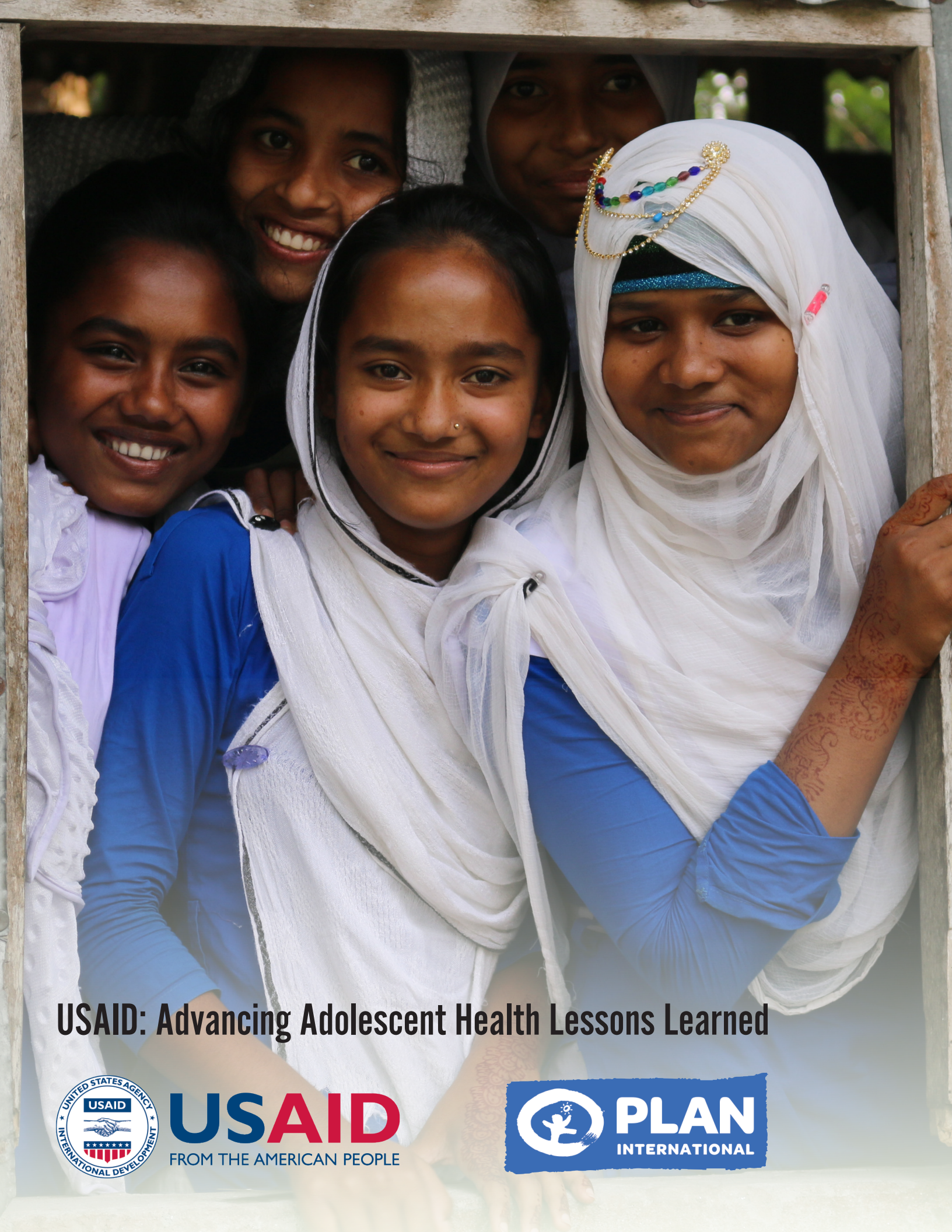

USAID: Advancing Adolescent Health Lessons Learned

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Background

In 2015, the adolescent population (10 to 19 years) of Bangladesh was approximately 36 million, or one-fifth of the total population of the country.[1] This significant adolescent population presents a demographic window of opportunity, which if well harnessed and invested in, will contribute to the development of the country. However, issues of early marriage (before age 18 for girls and 21 for boys), early pregnancy (before age 20), and poor family planning, particularly in rural areas, threaten adolescent health, well-being, and potential economic productivity. Investment in adolescent health could have a direct effect on Bangladesh's national health goals and economic development, as well as on the achievement of the Sustainable Development Goals (SDGs), particularly goals three, four, five, and eight. To align with the SDGs, the Government of Bangladesh developed the "National Strategy for Adolescent Health 2017-2030." The strategy outlines the areas the country will invest in related to adolescent health.

Improving adolescent health in Bangladesh would contribute to the achievement of the following SDGs:

Goal 3: Ensuring healthy lives and promoting well-being at all ages

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5: Achieve gender equality and empower all women and girls

Goal 8: Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all

Program Description

The USAID-funded Advancing Adolescent Health (A2H) project was a three-year program (2016-2019) designed to improve adolescent sexual and reproductive health (ASRH) and family planning knowledge, access, and use of related services for married and unmarried adolescents in Bangladesh. The A2H program was implemented in eight upazilas and three wards in the city corporation of the Rangpur district. The project was structured to allow for multi-level interventions targeting specific married and unmarried girls and boys ages 10 to 19, as well as key community gatekeepers and health service providers. The project sought to increase the demand for quality ASRH and family planning services, as well as encourage delayed marriage, healthy birth spacing, and improving health services and facilities. The program was implemented by Plan International USA and Plan International Bangladesh in collaboration with local partners Eco-Social Development Organization (ESDO) and World Mission Prayer League (LAMB Hospital). Specific objectives of the A2H program were:

- To deliver ASRH, family planning, nutrition, and life skills training to married and unmarried adolescents age 10 to 19;
- To strengthen adolescent-friendly sexual and reproductive health, family planning, and confidential counseling services in both government and community health centers; and
- To engage key community gatekeepers to become resources and advocates for the prevention of child marriage, delayed age at first birth, and healthy birth spacing, as well as increase the utilization of improved health, sexual and reproductive health, and family planning services by adolescents.

[1] National Strategy for Adolescent Health 2017-2030 December, 2016. Retrieved from http://coastbd.net/wp-content/uploads/2017/07/National-Strategy-for-Adolescent-Health-2017-2030-Final-Full-Book-21-06-17.pdf on December 18, 2018

Key Program Achievements

Over the three-year implementation period, the A2H program achieved the following:

- 307,914 adolescent girls and boys, received life skills training;
- 50,300 adolescents received sexual and reproductive health services from Union Health and Family Welfare Centers (UH & FWC) and Community Clinics (CC);
- 3,632 married adolescents and newlywed couples were educated on family planning, contraception, birth spacing, and birth registration;
- 4,830 religious leaders were oriented on adolescent sexual and reproductive health;
- 53,702 parents and community leaders were oriented and engaged to promote sexual reproductive health; and
- 250 adolescent girls from marginalized families were engaged in economic empowerment activities.

Lessons Learned

Findings from the A2H program reinforce that, despite social and cultural norms that have traditionally limited adolescent access to sexual and reproductive health information and services, adolescents, families, and community leaders are eager to learn about and tackle issues of early marriage, family planning, and ASRH. During the course of implementation, the team found that through the use of simple tools, engaging adolescents and community members to take ownership of program initiatives, and ensuring that program activities address key knowledge gaps, behavior change initiatives could be successful.

1. The use of simple tools can have far-reaching effects on changing adolescent behavior.
Adolescents, particularly those living in communities where issues of sexual and reproductive health are taboo, are often hesitant to discuss their questions and concerns with health care providers. With limited access to sexual and reproductive health information, adolescents often lack the ability to clearly articulate

"I got married at an early age, but I wouldn't let it happen with my daughter although we're poor. My daughter will study and shall become self-dependent!"

- Parent, Rangpur Sadar

Adolescent girls wait with their referral slips to see a health service provider.

"Earlier, people used to tell that you're a girl; you won't be able to do this… to do that. But after A2H I've been confident that girls can do everything. This session broke out the ice of shyness. Now I can discuss about our physical problems with my parents."

- Adolescent girl, Pirgacha

"Through referral slips we visited the health center and received counseling and services. They delivered the services [while] maintaining confidentiality. In addition, we also came to know about other services available in the FWC."

- Adolescent boy, Mithapukur

their issues and fear that confidentiality will not be maintained. To overcome this barrier, A2H developed a simple referral slip through which adolescents could communicate their concerns and questions with a health service provider. During sessions with the Community Facilitator (CF), adolescents could confidentially discuss their health concerns. The CF would then document the adolescent's concerns on the referral slip, which the adolescent would take to their community health care provider. Over the life of the project, referral slip usage increased from 23,895 in 2017 to 33,690 in 2018. Once at the health care facilities, many adolescents were able to receive additional services, broadening both their access to and understanding of ASRH issues. In addition to making adolescents more comfortable with seeking health services, the referral slip also helped make the provision of services more systematic for health care providers. Using the referral slips, health care providers were able to more accurately provide care, as well as easily track the adolescents who sought care. They were also able to track their primary concerns.

2. Engaging religious leaders as champions can be an effective approach to changing attitudes, especially among males.

The key to success in promoting delayed marriage and ASRH education is community acceptance of these concepts as appropriate norms. In the A2H project communities, religious leaders are a primary stakeholder in upholding and changing social norms. Given the sensitive nature of child marriage and ASRH, A2H expected religious leaders to be wary of participating in the program. However, by identifying and engaging 42 key religious leaders through awareness and training sessions, the project was able to solicit buy-in and convince the religious leaders to become champions of change in advocating against child marriage. Following the trainings these religious leaders became key advocates in engaging communities and spreading awareness about the importance of preventing child marriage. The program found that religious leaders were particularly effective in engaging and changing attitudes of male community members, as the religious leaders incorporated A2H messages into their Friday prayers, which were predominantly attended by men.

A religious leader talked to community members about adolescent health.

"Referral slips have made our work easier. In many cases, adolescents feel shy to disclose their problem related to sexual and reproductive health. By the referral slip we can easily understand the problem, and can refer easily if required. It also helps the person to whom the adolescent is referred in giving appropriate care."

- Healthcare provider, Badarganj

"Before I received any orientation from A2H I didn't think much about the age of marriage. Now, when someone calls me to conduct a wedding I concentrate over the age of the bride at first. If she is below 18, I deny to register the marriage right away. I feel that adolescents are our children. It's our responsibility to ensure a good future for them."

- Religious leader, Pirganj

3. Peer-to-peer networks are essential to ensuring ownership over initiatives.
Aligned with USAID's Positive Youth Development model, the A2H program built in a peer-to-peer approach to program implementation. Through the life skills sessions, adolescents had space to interact with each other and openly and confidentially discuss their questions and concerns around ASRH. The project engaged and empowered adolescents to serve as Adolescent Leaders and run the life skills sessions for their peers. Although the project understood the potential impact of peer networks, given the long-standing cultural taboos around ASRH, the program did not anticipate the peer networks to be as engaged and ambitious as they were. Using their peer networks, the adolescents advocated for the creation of adolescent forums to push their issues forward. The adolescents used these forums to establish community initiatives including spreading awareness about the importance of preventing child marriage, distributing sanitary napkins in schools, and collecting funds to meet educational expenses for disadvantaged students. The adolescent networks also established relationships with local leaders and government administrators in order to continue activities after A2H implementation ends.

4. The use of multimedia platforms can help decrease bias in program delivery.
Sociocultural gender norms and taboos around young people's sexuality often restrict their access to ASRH services and information. As the lynchpin to the life skills training session, it was essential for CFs to remain neutral in the delivery of the curriculum. The A2H program provided in-depth training to CFs on ASRH rights, how to discuss sensitive topics, and how to create a safe and open environment for adolescents to discuss their ASRH questions and concerns. However, even with extensive training it can be difficult to eliminate facilitator bias around long-standing cultural beliefs. To help reduce bias, the A2H program used the Aponjon Koisher app, a multimedia platform that CFs used to deliver the life skills training sessions. The Aponjon Koisher app helped reduce bias by standardizing the information and streamlining the messaging into a simple and easy-to-use multimedia platform. In addition to reducing bias, the project also found that adolescents were more engaged during sessions where the multimedia platform was used.

[2]A Kazi is a religious leader.

An Adolescent Leader speaks her peers about topics related to sexual and reproductive health.

"When we have peer-to-peer network, we can work together. As an adolescents' group we built awareness among the parents. By this we have been able to prevent child marriage. A2H has already oriented citizens from all levels, now we integrate them so that no one is convinced to marry a child. As a result, none can take a fake birth certificate from the Union Parishad; even the Kazis[2] are resistant to conduct child marriage."

- Adolescent leader, Pirganj


A Community Facilitator uses the Aponjon Koisher app to facilitate a life skills session with adolescent girls.

5. Community sales agent programs must be adjusted to the specific needs of adolescents.
Following the life skills trainings, the program received requests from adolescent girls to set up a community sales agent (CSA) program. The adolescents explained that many young women felt uncomfortable purchasing feminine hygiene and reproductive health products from male shop owners. Building off of the success of the USAID-supported Social Marketing Company (SMC)[3], the CSA program was both an opportunity for adolescent girls to contribute to their household income and address the unmet reproductive health needs in their communities. Through the CSAs, married adolescent females contributed to improving access to essential contraceptive, nutrition, and menstrual hygiene resources in remote areas via a door-to-door service. In addition to providing access to reproductive health care products, the CSAs also raised awareness about ASRH rights amongst their married and unmarried peers. However, through implementation the program found that the SMC model was not one-size-fits-all and that adolescents faced unique challenges to operationalizing their businesses. Most importantly, adolescents lacked the capital needed to invest in purchasing supplies. To mitigate this challenge the program established a partnership with SMC to provide adolescents with small start-up loans to build their inventory. Through this activity, 206 CSAs were able to purchase 1,389,952 BDT (17,374.40 USD) worth of products and generated 301,886 BDT (3,773.57 USD) in profits. Realizing the initial success of the CSA program, SMC agreed to continue implementing the activity after A2H concluded.

An community sales agent explains and sells feminine hygiene products to adolescents in her community.

"Family planning products in our village were not available before A2H activities. Now I sell family planning commodities to married adolescents and others. I also sell sanitary napkins and oral saline. People in my village and beyond know me as 'Family Planning Apa[4].' It gives me a sense of pride that I have been able to create my own identity through this work."

- CSA, Mithapukur

6. A basic understanding of ASRH issues among health providers should not be assumed.
Availability of and access to ASRH services is often restricted due to the lack of trained professional staff. Through the delivery of trainings, A2H found that many health care providers lacked a basic understanding of ASRH needs and issues. Due to prevailing cultural norms around sexual and reproductive health, the government's health service provider curriculum does not address adolescents as a unique population with specific care and service needs. As a result, health care providers are not well equipped to provide counseling, care, and services in an adolescent-friendly manner. To address this knowledge gap, the A2H program modified its training curriculum to focus on approaches and techniques for creating a comfortable and safe environment for adolescents to access health information. The training included guidance on confidential counseling, providing adolescent-friendly spaces, and how to talk to adolescents about family planning.

Recommendations

The lessons learned from the A2H program affirm that community-based programming can be effective

[3]The Social Marketing Company (SMC) was initially set up by an agreement with Populations Services International (PSI), USAID, and the Government of Bangladesh (GOB) as part of the Family Planning Social Marketing Project (FPSMP). https://www.smc-bd.org/index.php/common_modules/index/23
[4]An Apa is a term meaning sister and is often used to describe older women in the community.

A health service provider meets with an adolescent youth to talk about her health.

An Adolescent Leader facilitates a session on understanding your sexual and reproductive rights.

in helping to change norms around sensitive topics such as child marriage and adolescent health. They highlight the need for simple tools to address cultural barriers to receiving services; empowering adolescents to advocate for their rights; and engaging community leaders and health care providers with information and methods to positively interact with adolescents around sensitive topics. The following recommendations are intended for organizations, donors, and host governments designing and implementing ASRH programs.

• **Develop simple tools that can be easily used.** When working with adolescents in low-resource environments, simple tools can have far-reaching effects when it comes to changing behaviors. In the case of ASRH, referral slips were able to improve communication between adolescents and health care providers. Projects should engage beneficiaries and stakeholders to find simple solutions to what can often be larger barriers to accessing services.

• **Engage religious leaders as champions of change.** In the case of the A2H program areas, religious leaders were open and willing to engage with the project around the issues of child marriage and ASRH. Their engagement and influence had widespread effects as they embedded ASRH messages in their prayers. When seeking to influence long-standing social norms, implementers should identify key religious leaders as champions to promote change.

• **Support peer-to-peer networks to promote ownership and sustainability.** Adolescents in the A2H program areas were eager to learn about and push forward initiatives to improve access to ASRH information and services in their communities. By creating safe spaces where adolescents could discuss these topics with their peers, the program was able to harness the power of collective action, supporting adolescent ownership of the program and helping to establish a platform through which initiatives can continue beyond the life of the project.

• **Utilize multimedia platforms to reduce bias.** Awareness and training alone cannot eliminate bias around long-held social and cultural beliefs. Multimedia platforms can help reduce bias by standardizing and streamlining information. Additionally, multimedia platforms can be used to facilitate discussions that would otherwise be uncomfortable for adolescents and service providers.

• **Conduct baseline needs assessments to identify knowledge gaps and social barriers.** A comprehensive understanding not only of the official health care provider curriculum but also of the social and cultural norms that affect ASRH behavior and education is necessary to design effective interventions. Prior to developing a training curriculum, implementers should conduct a comprehensive needs assessment with local government partners, health care providers, and community members to understand the knowledge gaps and potential biases that could affect implementation.

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