BANGLADESH ADOLESCENT REPRODUCTIVE HEALTH STRATEGY

LIST OF CONTENTS

Chapter 1
THE CONTEXT: GOALS AND REALITIES

1.1 Adolescents' Reproductive Health in Bangladesh: A Socio-cultural Perspective

1.1.1 Defining adolescence:

Adolescence is generally accepted as a period of rapid and important change- the transition between childhood and adulthood. Although it is generally accepted that the onset of adolescence is marked by the appearance of secondary sexual characteristics (which again vary from individual to individual), the termination of adolescence- i.e. the beginning of adulthood is less well marked. It is also a period of rapid development when young people acquire new capacities and are faced with new situations that create not only opportunities for progress but also risks to health and well-being. It is a time when growth is accelerated, major physical changes take place and differences between boys and girls are accentuated.

A universally accepted definition categorizes those belonging to 10-19 years of age as adolescents. This period is further staged into early adolescence (10-14 years) and late adolescence (15-19 years). The WHO definition of adolescents has been extensively used worldwide to identify adolescents and to plan and operationalize programmes for them. *This Strategy is built upon this universally accepted definition of adolescents.* The definition however masks the huge heterogeneity found in this group, in terms of the physical, mental and social characteristics of the adolescents, their dynamics with the society, and their behaviour and responses. The reproductive health needs vary greatly within this broad age range, 1 which encompasses individuals who may be married or unmarried, sexually active or have not yet entered into that kind of relationship, girls who have already experienced childbirth, etc. Marriage is a particularly critical landmark event. Once married, the girls or boys are socially considered as adults, while those of similar age but unmarried and/or in school are considered as children/less mature.

In Bangladesh, adolescents represent more than one fourth of the total population.

Although adolescents are the healthiest members of the communities having survived infancy and early childhood diseases, they face a number of important health risks arising out of early pregnancies, violence, inadequate nutrition etc. Their sheer number also makes them an important determinant of the overall health status of the country.

1.1.3 Adolescents and socio-cultural background

Although at the prime of their life, an estimated 1.7.million adolescents die every year mainly from accidents, violence, pregnancy related problems or illnesses that are either preventable or treatable. Many more develop chronic illnesses that damage their chances of personal fulfillment. Among adolescents, the experience of girls and boys differ widely. Gender discrimination in the form of discrimination against girls has been identified as one of the prime adolescent reproductive health (ARH) issues in Bangladesh. The discrimination exists in most spheres of life including employment, marriage, social mobility, food allocation etc. However, recent government initiatives to encourage girls' education, including universal free primary education and stipends for girl students, have initiated groundbreaking positive trend in girl's enrollment in schools where, at secondary level, they outstrip boys in number (51 percent for girls and 49 percent for boys).

There is a wide disparity in opportunities available to rural versus urban adolescents. Higher frequency of early marriage among girls, early dropping out from schools and, for boys, early joining of work to supplement family income are some of the hallmarks of rural adolescents. While urban adolescents belonging to middle and higher income families enjoy better lifestyle, their counterparts from lower socio-economic situations have to struggle for survival and grow in impoverished, disadvantaged environment where malnutrition, poor health, exposure to antisocial activities and drugs etc. continuously plague them.

Families remain the cornerstone of Bangladeshi lives. In rural areas, most families are extended. In urban areas, there is a growing trend of nuclear families. Whether in rural or urban areas, parents and elders in the family exert a profound influence and control on the lives of adolescents. Their accesses to information, freedom of movement, marriage, practice of certain behaviours are closely regulated by parents or by the influencing members of the family. Outside the immediate family, teachers, close relatives and

community leaders also influence their lives, more often acting as barriers than as facilitators to adolescents exercising their simple rights.

1.1.4 Marriage, pregnancy and contraception

In spite of set minimum legal age for marriage (18 years for girls and 21 years for boys), early marriage, especially among female adolescents, is prevalent in Bangladesh with about 11 percent of those in the 10-14 years and 46 percent of those in 15-19 years being married.

Marriage at an even earlier age is common in rural areas where about 85 percent of the girls are married before they reach the age of 16. Increasing trend of dowry, lack of safety and security of young girls and less economic value attached to girls are some of the reasons for continuing early marriage. Once married, the girls are under pressure to prove their fertility, and as a result pregnancy closely follows. One third of adolescents aged 15-19 have begun child bearing, 28 percent have given birth and another 5 percent are pregnant with first child. Childbearing begins earlier among adolescents in the poorest 40 percent of the households. Fertility rate among the 15-19 years old is about 135 per 1000 women, one of the highest in the world for this age group. Contraceptive use is low- 42 percent as opposed to the national average of 58 percent. Due to inherent risks of early pregnancy, maternal mortality rate is higher in this group-about 4 times higher than the national average. Low birth-weight is more common among babies born of this group of women than among older women. Young girls facing unwanted pregnancies are known to resort to unsafe abortion, in spite of the existence of a wide network of menstrual regulation (MR) providers. This often results in morbidities which girls have to suffer from for the rest of their lives.

1.1.5 Nutrition

The nutritional status of adolescents in Bangladesh is deplorable. Sub-optimal nutrition during adolescence is mainly the consequence of interaction of socio-economic and environmental factors. Lack of proper knowledge, incorrect food habits, inability to fulfill additional dietary needs during pregnancy are some of the major causes which lead to this state. In a study conducted among students up to class X, girls were found to have better nutritional indices than boys; thereafter, the scenario completely reversed, possibly due to prevailing norms, which adversely affected food distribution in the family. In rural areas, early and repeated childbearing further compromise the nutritional status of girls

which contribute to higher maternal mortality rate and greater incidence of low birth weight babies in the rural areas.

1.1.6 Education and employment

Education and employment are both known to positively impact on reproductive health by creating enabling environment for acquiring knowledge and information, accessing services and practising positive behaviours. Bangladesh has made important strides in the education sector in the recent past. Large scale government intervention, through scholarships/stipends and other incentives, as well as provision for free education for all upto primary level and for girls up to class XII, has increased enrollment at both primary and secondary educational levels and the gender gap has been largely narrowed. About 88 percent of girls aged 15-19 years are now enrolled in schools. In spite of these recent achievements, dropout rates continue to be high, especially among girls, many of whom discontinue in order to get married. Outside formal education, the extensive network of non-formal education, primarily operated by NGOs, has been successful in providing older girls with basic reading and learning skills. Educational attainment is higher in urban than rural areas with 28 percent girls in urban and 36 percent of girls in rural areas having no education. The corresponding figure for boys was 20 percent for urban and 29 percent for rural areas.

About 18 percent of the 10-14 year old and 57 percent of the 15-19 year old adolescents are employed. The employment rate is higher in urban than in rural areas among both age groups except 15-19 year old boys, among whom a larger proportion was employed in the rural than in the urban areas[10]. This statistic however clouds the fact that most of the girls, especially in rural areas, are heavily involved in household chores, often disproportionate with what their bodies can cope with. The pattern of employment also varies between the rural and urban areas. While in rural areas, most employment is in the agriculture sector, a large proportion of urban girls and boys, especially the earlier group, work in the rapidly expanding industrial sector, including the garments factories. Long working hours, adverse work environment and lack of adequate access to basic amenities put adolescents working in this sector at higher health risks and risks of sexual abuse. This situation also makes their access to the usual network of health services difficult. A large number of adolescents also work as domestic helps, although their number is unknown. Physical abuse including sexual abuse is not uncommon among those employed as domestic helps, as evidenced by a number of newspaper reports in the recent past.

1.1.7 Violence, exploitation and abuse

Violence against adolescents takes many forms-physical, sexual and psychological. They are exposed to all prevalent forms of violence against women- e.g. dowry related violence, marital rape, sexual harassment and intimidation at work, trafficking, forced prostitution, acid throwing, rape etc. It is difficult to get accurate data on such violence. However a review by UNICEF indicated that the mean age for sexual abuse was 11.6 years, and most rape cases took place among very young girls, including children. About a quarter of child domestic workers were sexually abused, and most acid survivors were under 18. In spite of existence of tough laws, acid violence continues unabated, with an average of 250 cases being reported annually. Trafficking women, most of whom are in their teens, across the border to neighboring countries has become a regular affair. The fact that an estimated 300,000 young Bangladeshi girls work in the brothels of India while 200,000 women have been trafficked to Pakistan over the last 10 years, demonstrate the magnitude of the problem. While sexual abuse of boys is much less talked about, there are anecdotal experiences on record of prevalence of such violence at household as well as institutional levels.

1.1.8 Sexual and other high risk behaviour among adolescents

Sexual activity among adolescents is not restricted only to the married ones. Although social customs and values discourage premarital or extramarital sexual relationship, increasingly there are reports of prevalence of such behaviour. Five percent respondents in a survey on adolescents reported premarital sex.In yet another study, less than 1 percent of unmarried girls and 8 percent of unmarried boys reported having sex Young men, including adolescents boys, are known to visit sex workers and about a third of them are reported to have used the services of sex workers. This group is especially vulnerable to unwanted pregnancy and disease, including sexually transmitted infections (STIs), HIV infection and the stigma and discrimination associated with either condition. Male to male sex is not uncommon, and often adolescent boys are forced to participate in such sexual acts. Due to lack of awareness and information, most of these sex acts are unprotected and result in the spread of sexually transmitted infections. This is evidenced by high proportions of male adolescents reporting that they knew of people who suffered from such diseases (88 percent). Drug use, including use of injecting drug among them is on the increase. Injecting drug users share needles routinely, greatly increasing their

chances of contracting HIV/hepatitis and other blood borne infections. Older adolescents, especially in urban areas, are getting more and more involved in violence and crime. Use of adolescent boys for perpetrating hartal violence is common. Many of the small time drug peddlers are young teenagers.

Thus a huge range of risky behaviours is seen among today's adolescents, all of which directly or indirectly also impact on their reproductive health.

1.2 Bangladesh's Response to Adolescent Reproductive Health Issues

1.2.1 Legal and Policy Framework

The Bangladesh Government (GoB) has shown exemplary farsightedness in creating an overall supportive policy and legal environment to promote adolescent reproductive health. The Constitution of Bangladesh guarantees equal rights for men and women irrespective of caste, creed, and colour. All citizens are entitled to equal protection under the law. A number of laws are in places which directly or indirectly dissuade adverse practices. These include the Dowry Prohibition Act, 1980 which provides taking and giving of dowry an offence and punishable by fine and imprisonment; Cruelty to Women (Deterrent Punishment) Act, 1983 which makes punishment by death or life imprisonment for the kidnapping or abduction of women for unlawful purposes, trafficking women or causing death or attempting to cause death or grievous injuries to wives for dowry; the Immoral Traffic Act and the Women and Children Repression (Amendment) Act, 2000 enacted to regulate offences (like sexual harassment, rape, trafficking, kidnapping, dowry) against women; the Child Marriage Restraint Act, 1929 (Amended in 1983) enacted to restrain child marriage and ascertain the legal age of marriage, which is 21 years for boys and 18 years for girls, and the Children Act, 1974 which provides provisions relating to protection and treatment of children and trial and punishment of youth offenders.

The Government of Bangladesh has recognized the importance of ensuring ARH and has incorporated this issue in important national policies. The Population Policy of 2005 has provision of information, counseling and services for adolescents as one of its objectives and outlines a number of strategies for achieving this goal. The Policy addresses the

ARH issue not just from the population but also from a development perspective, which is a major breakthrough. The Policy puts special emphasis on providing vocational and non-formal education to both in-school and out-school adolescent boys and girls.

The National Health Policy of 2000, on the other hand, does not contain any explicit mention of the adolescents or address the ARH issue, though the objectives and strategies are comprehensive enough to encompass the issue. The newly adopted Youth Policy has, as one of its objectives, involvement of youth in issues of national importance such as preventing the spread of HIV/AIDS and drug abuse, and specially mentions the importance of involving members of the society in imparting youth with knowledge about reproductive health.

The Reproductive Health Strategy developed under the leadership of the Ministry of Health and Family Welfare (MOHFW) outlines improving services for married adolescent girls as a priority area for action. The health of adolescent girls is identified to be a critical issue and the role of education, employment and empowerment is acknowledged as a necessary condition for improving their reproductive health. The National Maternal Health Strategy considers improving the access of adolescents to emergency obstetric care and sexual and reproductive health services as a priority. Objectives set under this Strategy are broadly supportive of ARH; specifically, objectives related to reducing low birth weight, improving maternal nutrition, making health services more sensitive to women's needs, building zero tolerance against violence in health facilities would directly contribute to improving the ARH status. Providing easy access of adolescents to information about sexual health and safer sex practices and relevant services has been emphasized in the National HIV/AIDS Policy.

In reality, there has been limited impact of these favourable laws and policies. 'Reported' acid and dowry violence is decreasing slightly, age at marriage is showing gradual increase and there is increasing sensitivity to sexual abuse and violence against the adolescents. However, law enforcing mechanisms in Bangladesh are weak and, given a cumbersome legal system, very few people have recourse to law. Similarly, lack of focus on operationalising policies and strategies and inadequate monitoring of progress have detracted from the benefits, which could have been achieved by implementing these policies and strategies. Moreover, such policies and strategies are often drafted in isolation, and as a result the synergy which could be derived from operational sing different policies is missing. Formation of an Interministerial Committee on the issue of

ARH and better coordination or synergy could be achieved in the future on this particular strategy. Several socio-cultural factors, including improved access of adolescents to education, the rapidly developing media access, increasing recognition of importance of protecting the health of adolescents, and a slowly developing effective local government structure, offer excellent opportunities for accelerating progress in this regard.

1.2.2 Interventions in the Government Sector

ARH has so far been mainly a concern of the Ministry of Health and Family Welfare, though other ministries have of recent integrated ARH issues in some of their projects/programmes. Important programme initiatives undertaken by MOHFW on this issue include steps to train providers on adolescent friendly health services and introduce ARH services in Maternal and Child Welfare Centres (MCWCs) and countrywide project under Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) to prevent the spread of HIV/AIDS among young people. Nutritional supplementation of pregnant mother with iron /folic acid, introducing skilled birth attendants and expansion of Emergency Obstetric Care (EOC) services, initiatives to improve quality of care in government centers are other initiatives which will directly contribute to improving ARH especially of adolescent mothers.

A number of other ministries have also come forward on this issue. The Ministry of Local Government, Rural Development and Cooperatives, under the Urban Primary Health Care Project (UPHCP) has embarked upon an ambitious programme to introduce health services to a large number of municipalities and all City Corporation areas in phases. Under an ongoing project covering 4 of the 6 City Corporations, Adolescent Spaces have been set up in all health facilities under the project. The Ministry of Education's inclusion of ARH issues in the formal curricula of schools and religious institutions is a major step in breaking the silence around ARH issues. The Ministry of Social Welfare, through its centres for street children and juvenile delinquents, is providing valuable support to extremely marginalized groups of adolescents, though the number of such centres is grossly inadequate and important opportunities are missed for promoting ARH through them. Legal support and skills training provided to women, including adolescent girls, by the Ministry of Women and Children's Affairs, and the Ministry of Youth and Sports' youth advocacy, along with provision of livelihood training and peer education through the Youth Clubs, are other important initiatives which deserve special mention.

Although the ARH issue has received the attention of a range of ministries, most of the programmes are being implemented vertically, resulting in a lack of sustainability of the initiatives. The MOHFW interventions are anchored in existing programmes and therefore could continue in the long term. ARH is already included in various curricula, although the fact that teachers avoid taking classroom sessions on the topic due to shyness is a huge drawback. Most of the initiatives of other ministries are through externally funded projects and could cease after the funding is withdrawn. Their scale is also modest in relation to the need, except in the case of the Ministry of Youth and Sports, which works through (*information to be added by Dr. Noor Mohammad, UNFPA).*

1.2.3 Role of NGOs and other private sector enterprises

The NGOs have played a pioneering role in this area by catalyzing the inclusion of this important topic in the national agenda on the one hand and establishing programmes for adolescents on the other. NGO interventions have mainly been on provision of health education and awareness building, delivery of health services for adolescents, and peer education and life skills approach for enabling them to establish their rights. A large number of NGOs- local, national and international have been involved in designing and implementing interventions. Many of these interventions have used innovative approaches and have been truly responsive to the needs of adolescents. Some of the programmes have been particularly successful in addressing highly marginalized groups such as those living on the street and employed in risky jobs and work in hazardous environment. A number of well researched and effective tools and materials have been produced.

In spite of a long engagement of the NGOs in this sector, there has been limited impact of the intervention by NGOs. Reasons for this are manifold, the most important being the fact that these interventions have been mostly implemented through donor financed projects carried out in localized areas, and at a scale not large enough to generate a critical national response. Rural areas have been largely neglected, and due to dependence on external funds and limited opportunity to make these interventions financially viable, the interventions have been short-lived. Due to lack of coordination and collaboration, the synergy which could have evolved, was lost. An NGO networking forum, NEARS, has been launched and an existing one, DAWN, has been revived. These forums could play a critical role in promoting the issue of collaboration and coordination among the NGOs.

The for-profit sector had so far played a rather limited role in this area. Most of the involvement has been in carrying out research, although under GFATM a public-private partnership is evolving where the private sector expertise and experience is being used to develop messages and materials.

1.2.4 ARH and the Development Partners

The Development Partners, including the UN agencies and bilateral and multilateral donors, also have a long history of involvement in the area of ARH, which is reflected as a priority of most UN agencies working in the health sector including WHO, UNICEF, UNAIDS, IOM, ILO, UNFPA etc. The focus of these different agencies differs, but together they encompass all the facets of the issue, including education, health, nutrition, establishment of rights, empowerment and systemic issues such as monitoring progress and promoting youth participation. The role of bilateral donors has mainly been to support, through technical as well as financial inputs, projects and programmes of NGOs. Along with the UN agencies, these bilateral agencies have played a valuable role in highlighting the importance of ARH.

1.2.5 International commitments to ARH

Bangladesh has made important commitments on ARH to the international community. Bangladesh is a signatory to International Conference on Population and Development (ICPD), ICPD+5, Child Rights Convention, Beijing Platform of Action, and the Millennium Development Goals (MDGs). Given the huge number of adolescents in the country and their potential role as change agents, any small improvement in the ARH status of adolescents can actually trigger an accelerated achievement of the other goals and targets. Already there have been important gains that have helped to push up Bangladesh's ranking in the Human Development Index list, and Bangladesh is well poised to meet some of the MDGs, including the one on education.

1.3 Opportunities for the future

The importance of improving adolescent reproductive health has been realised by the Government of Bangladesh since long. Successive national level policies/programmes in the health sector (the Population Policy, the HIV/AIDS Policy, HPSP and HNPSP) have paid importance to the issues, programmes have been launched in both the government and NGO sectors, and the topic has also been successfully taken up by the media. The legal framework of the country provides a supportive environment and Development

Partners have been actively supporting the issue. Against this backdrop, the Government of Bangladesh felt that it was of paramount interest to the country to have a National Strategy in place to develop the issue further in a concerted and coordinated way, and work towards a consensual goal.

The development and introduction of the Strategy at this point of time would also present important synergies for implementation of the Strategy. The local government institutes, with appropriate orientation and sensitization, were poised to play an effective role as change agents. Local government leaders, including Union Parishad members, Ward Commisssioners, etc. working in coordination with other parts of the civil society, could, through the Parliamentarians and the Parliamentary Standing Committees, take the issue up to the national Parliament for debate, discussion and passing of appropriate laws. Several well spread out infrastructures within the society are well positioned to take this development further. This includes the formal infrastructure of health and education, both government and private, the National Nutrition Programme of the government, other parts of the civil society, e.g. the network of Scouts and Girl Guides, BDRCS volunteers in the coastal areas, and members of the Youth Clubs, who are already aware of the issue and whose energy can be built upon to transform the ARH issue into a movement.

The role of media would be critical in promoting the ARH issue. Through involvement in various adolescent related interventions, a large section of the media has already been primed on the issue, and its influence can be harnessed to further accelerate change. As a result of expanding media influence, communities are more ready to embrace change now than ever before. The corporate sector of the country has so far played little role. However, with the introduction of open market economy and rising trade and consumerism, the corporate sector, as part of social responsibility, is getting involved in issues such as prevention of smoking among young people, building awareness against HIV/AIDS, etc. There is a huge opportunity for more systematic and greater involvement of this sector in ARH issues, given the large client/customer base that adolescents provide to some of the big corporate entities.

There also exists a critical mass of experience, skills and technical resources in the country to rapidly expand ARH programmes. Effective tools and training programmes have been developed, innovative peer approach strategies have been tested out, links have been forged between adolescents and their gatekeepers and collaboration between the government and NGOs has been established. It is therefore a prime opportunity for all

sectors of the Bangladeshi society to come together to develop adolescent reproductive health.

1.4 Strategy Development Process

In 2002, a two days' sensitization workshop on Adolescent Health and Development Strategy in Bangladesh was organized by Obstetric and Gynaecological Society of Bangladesh (OGSB) and Institute of Child and Mother Health (ICMH), with funding from World health Organisation (WHO). The workshop discussed the issue of adolescent reproductive health within the broader framework of adolescent health and development. The next important step in developing the ARH strategy was taken in 2003 when an Inter-ministerial Committee was established under the Joint Secretary (Development-Family Welfare) of MOHFW to lead the process. The Committee included representation from 6 relevant ministries, UN agencies, NGOs and bilateral donors. During this time, preparatory steps were taken for development of the strategy through the commissioning, by WHO of a paper to review the situation of adolescents in the country. Several intermediary steps were taken by MOHFW for development of the Strategy, and ultimately a Strategy Drafting Committee was formed by the Inter-ministerial Committee in May 2005. The Strategy Drafting Committee included representatives from MOHFW, including the Directorates of Health and of Family Planning, Ministry of Youth and Sports, Development Partners (WHO, UNICEF, CIDA) and individual experts. A National Programme Officer (NPO) from UNFPA served as General Secretary of the Committee. The work of the Committee was facilitated by a Consultant appointed by UNFPA. The Strategy Drafting Committee was assigned the challenging task of developing the Strategy within a short time span of three months. The Drafting Committee, immediately after its formation, started intensive work and, after several meetings, developed a plan for the process of strategy development, which was approved by the Inter-ministerial Committee. Accordingly, the Drafting Committee organized a 3day workshop for development of the Strategy. A wide range of government, NGO, private sector, civil society and media representatives, including representatives of the adolescents, participated in the workshop. Through this workshop, the outline of a strategy emerged. Individual and group consultations at the national level, divisional level feedback from a cross section of stakeholders, and inputs and reviews from eminent experts were included and the Strategy was thus finalized.

The following Strategy represents the outcome of the Workshop and the combined

thoughts of policy makers, programme planners, implementing agencies in the government and NGO sectors, researchers and experts in the field, religious leaders, community leaders, media experts, philanthropists and representatives of other parts of the civil society. Most importantly, the Strategy also reflects the inputs of the adolescents themselves who were closely involved with the process of its development.

Chapter 2
The Framework of the Strategy

2.1 Guiding Principles

Bangladesh's ARH strategy rests on global consensus declarations on human rights including the right of all persons to the highest attainable standard of health; and on Bangladesh government's constitutional obligation to guarantee fundamental human rights and dignity to all its citizens. To ensure that the ARH Strategy fulfills these fundamental rights, development of the Strategy has been guided by the following eight principles:

1. ***ARH should be viewed as an overall development issue:*** Attainment of the highest standard of reproductive health by adolescents requires adolescents to be empowered to make decisions and act upon them, with support from all the gatekeepers. Education, access to information, affordability of relevant services, access to communication facilities, etc. therefore need to exist for development of ARH to the highest standards.
2. ***ARH should be embedded in all national planning frameworks related to human development:*** Since ARH is an overall developmental issue, it should be integrated in the development planning of the country at the national and sectoral levels. While important international and national commitments of the Bangladesh Government (MDGs, the ICPD, the PRSP, the Bangladesh Population Policy, which has placed a lot of importance on the issue) have ARH explicitly integrated within them, other policy frameworks should integrate this issue, either explicitly or implicitly through programmes.

3 ***The ARH Strategy should have special focus on marginalized and highrisk adolescent groups:*** The ARH Strategy should include all segments of the adolescents with special emphasis on adolescents living in rural areas, the poor, especially the hard-core poor, the marginalized, the disabled and adolescents with special needs. Girls as well as boys have unmet needs, and the Strategy should address the needs of both the sexes.

4 ***The Strategy should be gender sensitive:*** Being part of a traditional, conservative society, girls suffer from a number of gender based discriminatory practices which adversely affect their reproductive health. The Strategy should address these discriminatory practices in order to provide adolescent girls an enabling environment to grow and thrive in.

5 ***Wide scale community support should be generated:*** Communities and families are the ultimate facilitators and barriers to achieving the desired status of ARH For this, communities need to be involved in programmes. Bangladesh has strong traditions and cultures built around religious and family values. Programmes should build upon these positive traditions and cultures, and should be sensitive to the community's and society's points of view.

6 ***Sustainability of interventions should be aimed for:*** In designing interventions, long term sustainability should be kept in mind. To the extent possible, interventions should be anchored in existing programmes, and skill and capacity building of adolescents and institutions should be seen as elements of sustainability.

7 ***Adolescents should participate at all levels of planning and implementation:*** For the Strategy to be effectively designed and implemented, adolescents need to be made an integral part of the entire process. Participation of all segments of adolescents, especially the poor, marginalized, disabled and those with special needs, has to be ensured.

2.2. The Time Frame

The ARH Strategy spans over a period of 10 years, i.e. up to 2015. In the interest of more pragmatic planning, given the rapidly changing dynamics of the Bangladeshi society, changes in external situations, which impact on the country's economy and society, the impending hazard of a concentrated HIV epidemic, the changing funding situation etc., detailed planning is confined to the coming five years- i.e. up to 2010. Thus, a 'Vision' of this Strategy encapsulates a long term (10 years) objective, while the 'Goal' articulates

the more immediate (5 years) objective. Achieving the Goal would contribute to the Vision. However, as we near 2010, this Strategy would be revisited to adapt it to the changing scenario.

2.2 The Vision

By 2015, all adolescent girls and boys, including the disadvantaged, will be able to enjoy safe and complete reproductive life through access to appropriate knowledge, skills and services in a socially and legally supportive environment

2.3 The Goal

By 2010, all adolescents will have easy access to information, education and services required to achieve a fulfilling reproductive life in a socially secure and enabling environment.

2.4 The Objectives

The objectives of the ARH Strategy are

1. To improve the knowledge of adolescents on reproductive health issues.
2. To create a positive change in the behaviour and attitude of the gatekeepers of adolescents (parents/guardians, teachers, religious leaders etc.) towards reproductive health
3. To reduce the incidence of early marriage and pregnancy among adolescents
4. To reduce the incidence and prevalence of STIs, including HIV/AIDS, among adolescents

To provide easy access of all adolescents to adolescent friendly health services (ARSH) and other related services

To create a socio-political condition, where adolescents are not subjected to violence or abuse, and which discourages substance abuse and other risk taking behaviours among adolescents

Chapter 3
Strategies and Activities

In order to achieve the 6 objectives mentioned in the last chapter, a wide range of strategies would have to be undertaken, involving a variety of stakeholders and a number of sectors. Given the ambitious time frame and a limited resource envelope, the strategies have been defined in a way that would maximize impact and address the priority needs.

The following section describes the main strategies to be undertaken in order to achieve each of these objectives and the priority activities *which need to be completed by 2010.*

3.1 Strategies for improving adolescents' knowledge on reproductive health issues (objective 1)

3.1.1. Effective dissemination of ARH knowledge and information through school curricula:

ARH is included in the curricula of secondary and higher secondary schools and *Ibtedai* and *Dakhil* courses. However, the teaching of the contents remains weak, with teachers often skipping the chapters, or asking students to read them at home. Information contained in the chapters does not cover all aspects of reproductive health, neither does it generate a complete understanding of the issue.

The following ***priority activities*** therefore need to be taken to make the curricula more effective:

a) Review and revise existing curricula based on needs assessment

A needs assessment of all existing curricula would be carried out to assess if they meet the information needs of students. Besides the actual content, the needs assessment would identify acceptable style of presentation and the language to be used so that students themselves, their parents and teachers all feel comfortable with the chapters. As such, parents and teachers would also be involved in the needs assessment and review. The curricula would be revised in a way that will ensure progression of learning. There would be a chapter for each of the classes from class VI onwards, and the contents would deal not only with the biological but also the social and moral aspects of reproductive health.

b)Training of teachers on the revised curricula

Training of teachers must go beyond orienting them with the contents of the curricula, to empowering them to deal with reproductive health issues. A core group of trainers who would undertake training of teachers on a regional basis, need to be developed.

c) Implementing monitoring systems to ensure classroom teaching of the curricula

A mechanism needs to be devised, within existing monitoring systems, to ensure that after receiving training the teachers actually do teach the topic. School Inspectors could play a monitoring role. Inclusion of at least one question from the ARH chapter in annual school and Board examinations would also positively influence teachers in this regard.

3.1.2. Organising effective community- based dissemination of ARH information

Adolescents who are out of school, married adolescent girls, those in various kinds of employment, street children and the disabled have to be reached within their communities. A number of NGOs have successful peer-based community programmes. These NGOs could be supported to scale up existing programmes. The UPHCP in its second phase would be able to cover a large section of the urban adolescents. In areas where such NGOs are absent, those working in that area would be developed so that they can implement peer based approaches. These interventions must draw the support of religious leaders, parents and other community leaders. However, mechanisms would need to be instituted to avoid duplication and ensure quality of the intervention.

The ***priority activities*** which need to be undertaken for operationalising this strategy are:

a) Mapping of community-based existing interventions:

Based upon existing information, a mapping exercise would be undertaken to map those areas of the country where there are community-based interventions by NGOs. Areas

where there are gaps would then be identified.

b) Identifying areas with unmet need and participatory planning for meeting these needs: The mapping exercise would identify areas which are not covered by interventions. Community-based interventions in these areas would then be planned by using existing field-based networks (e.g. MOHFW's health/family planning field workers, Ministry of Youth's Youth Club members, Microcredit groups of NGOs etc). Existing interventions would be upscaled where possible. Interventions would be based upon successful experiences gained so far, and innovative approaches would be adopted to reach the more hard-to-reach adolescent groups. A lot of experience has already been gained on peer approach, and these experiences would be reflected in designing new initiatives.

c) Use of mass media: In those situations where community-based programmes cannot be extended, different channels of the mass media can be used to spread messages/information.

Key roles for this strategy would rest with a number of ministries (e.g. Ministry of Education, Ministry of Information, MOHFW, Ministry of Youth and Sports) and NGOs. There would be a lot of coordination involved, which would be undertaken by the Interministerial Committee mentioned in the next chapter.

3.2 Strategies for creating positive change in the behaviour and attitude of adolescents' gatekeepers (objective 2)

3.2.1 Carry out advocacy at community level for the gatekeepers of adolescents

Parents, teachers, religious leaders, community leaders, all act as gatekeepers of the adolescents, and sometimes create barrier in their way of accessing or practising new knowledge or skills. In order to create a more supportive attitude among them, advocacy at community level is required. This need not be undertaken as a new stand-alone intervention, but could be an add-on element to other community-based advocacy being carried out by different sectors. The ***priority activities*** which would be needed to carry out such advocacy include:

a) Review existing literature/conduct new research to understand concerns and beliefs of different categories of gatekeepers regarding ARH: This exercise would subsequently form the basis for developing materials and messages to be used among the gatekeepers.

b) Develop and disseminate key messages and materials: Existing community-based programmes and government's networks of field functionaries/offices would be the vehicle for dissemination of these materials. These programmes through locally arranged small seminars/workshops/talks/courtyard meetings would disseminate the messages and materials. In order to facilitate effective use of the materials in community-level advocacy, the materials would need to be accompanied by manual(s).

3.2.2 Develop and implement mass media campaigns

Based on the research results, mass media campaign for various categories of gatekeepers would be developed using radio, television and print media. This mass media campaign would support the community-level advocacy. The ***priority activities*** under this would include development and implementation of a media plan, which could include radio and television spots, and visual materials (stickers, brochures, bill boards etc.).

Both the Ministry of Information and MOHFW could take lead role in development and dissemination of the materials. A number of ministries, along with NGOs, would have to work together in order to reach a large number and different types of gatekeepers. The Interministerial Committee could again play a ***key role*** to ensure coordination and collaboration.

3.3 Strategies to reduce incidence of early marriage and pregnancy (objective 3)

3.3.1 Community mobilization against early marriage and pregnancy

Marriage decisions are primarily made by parents though close relatives and communities exert considerable influence. Once a marriage takes place, pregnancy naturally follows, as most girls are under social pressure to produce an offspring soon after marriage.

Therefore strategies for preventing early marriage would have parents, community leaders, including religious leaders, and marriage registrars as primary target group. The newly married adolescents, their husbands and in-laws would be the primary target group for preventing early pregnancy. The ***key activities*** to implement these strategies would include:

a) Communication campaign to generate awareness regarding early marriage and early pregnancy: The parents, community leaders, adolescents (married and unmarried) and families of married adolescents should be brought under this intervention. Specific materials will be produced/replicated and the topic should be integrated in the BCC/IEC/health education activities of all NGOs and MOHFW field staff. The mass media should also be used to disseminate the information.

b) Train local government leaders and community leaders to work as advocates: All Ward commissioners, Upazila/Union Parishad members, and informal community leaders should be given brief training on the issue and orientation on advocacy strategies that they can use. Participants should be provided with printed materials for the advocacy. The training should be integrated within other training programmes/meetings that they attend. Religious leaders and madrasa teachers should be encouraged to speak against the issue in all appropriate forums. The marriage registrars should be especially encouraged to advise against early marriage, and to refuse to register marriages where the minmum legal age of either partners is not met.

c) Publicity and setting examples: Instances where early marriage was successfully prevented should be appreciated, while instances of early marriage should be censured by the community. Newspaper reporters would be encouraged to cover such stories and local civil administration in selected exemplary situations look into the matter, to generate community sensitivity about the issue.

d) To form local level committees to prevent early marriage: Community leaders could take a leadership role in monitoring early marriage, and prevent or discourage it where possible.

e) Include the issue of early marriage and pregnancy in curricula: This topic would be addressed in the chapters on ARH (please see 3.1.1).

3.3.2 Strengthening implementation of existing laws

The implementation of laws related to early marriage, dowry and violence against women leaves a lot of room for improvement. A number of factors are responsible for this, including cumbersome legal process, lack of awareness of communities about existence of these laws, lack of awareness and sensitization of law enforcing agencies as well as

their vested interest.

Priortiy activities which need to be undertaken to strengthen implementation of these laws include:

a) Generating community awareness regarding the existence of these laws: This can be achieved through use of mass media and through local level community leaders.

b) Wider provision of legal aid to victims: There is very little opportunity for the victims to access legal aid. The network of legal aid facilities needs to spread further, and communities need to be made aware about the existence of such help. This will not only increase the access of victims to legal recourse but will also create a lot of local level publicity on issues such as early marriage, dowry etc and help to build public opinion against these.

3.3.3 Increasing access of married adolescents to family planning services

Family planning programme needs to focus on married adolescents, especially the newly married ones, so that their access to family planning services can be ensured. NGO and government field workers, who visit households or are in close touch with the community, are poised to play a critical role in this, identifying and visiting such couples and motivating them for method use. In order to accomplish this, the following ***priority activities*** need to be undertaken:

a) Include recording of newly married couples, including where the wife is an adolescent, in the FWA register: Such couples would be specially marked out in the FWA register .

b) Address adolescents during regular visits to households; motivate them for method use

c) Introduce FWA register and household visits of targeted couples in urban areas: In the absence of FWA registers in urban areas, it is impossible to identify the target couples and carry out household visits. These registers therefore need to be introduced in urban areas as well, along with household level visits. The UPHCP would be an appropriate vehicle for such introduction initially.

The ***key roles*** in implementing the above mentioned strategy would be taken by a number of Ministries including MOHFW, Ministry of Local Government, Rural Development

and Cooperatives, Ministry of Information. The Inter-ministerial Committee would play an important role in ensuring collaboration and coordination anyway the ministries. The NGOs would take on a supportive role in integrating related messages in their own interventions.

3.4. Strategies for reducing the incidence and prevalence of STIs, including HIV/AIDS, among adolescents (Objective 4)

3.4.1 Scaling up of and improving coordination between existing interventions

A national policy is already in place for preventing HIV/AIDS and STIs. A dedicated government department, the National AIDS STD Programme (NASP), is leading and coordinating efforts of preventing STIs and HIV/AIDS and a large number of NGOs and several MOHFW agencies are involved in programme implementation. A number of projects are in place, including e.g. a GFATM funded project aimed at the adolescents and youth, for generating awareness, service provision, advocacy, inclusion of HIV/AIDS in curricula, and research. Although these projects are great beginnings, implementation needs to quickly scale up and reach national levels, and ways need to be found to continue interventions after expiry of project life.

Inspite of this, the adolescents remain largely outside the purview of preventive activities, which usually target older age groups, clinic based clients, or high risk groups. Although some information on HIV/AIDS does trickle down to them through the mass media, such information has only been useful in creating awareness about the disease, but has not brought about changes in behaviour, for which more in-depth information and BCC is required.

In view of the above situation the ***priority activities*** for this strategy are:

a)Review of the progress of GFATM project and scaling up of the project activities: In case funding from GFATM is not available for nationwide coverage alternative sources must be identified.
b)Coordinate activities carried out by different NGOs and the GFATM project for greater synergy: A number of small to medium interventions are in place which need to be coordinated for better and greater impact. Also, ways need to be found for developing synergy between the GFATM activities and the existing interventions.

3.4.2 Dissemination of STI prevention messages in all available and appropriate channels

STI prevention messages are integrated in many of the HIV/AIDS related BCC interventions. There are other important opportunities for disseminating these messages using existing channels, including educational curricula, through mass media, through religious sermons, and through adolescent friendly services.

The ***priority activities*** which could be undertaken to achieve this strategy are:

a) Incorporation of STI related information in curricula: This topic should naturally be part of the contents of the ARH curricula mentioned under Objective 1 of this strategy

b) Involvement of religious leaders and other community leaders in disseminating information: A wide scale information dissemination intervention using religio-culturally sensitive material would be designed. The intervention would be carried out by well oriented community and religious leaders.

c) Development of appropriate materials and tools for effective BCC: A thorough review of existing BCC materials would be carried out and, based on that, new and appropriate material designed and produced.

3.4.3 Multi-sectoral advocacy for creation of supportive environment for adolescents to paractise safe behaviours

Once adolescents are equipped with proper knowledge, they need access to commodities and services, and an overall societal support so that they can practise the safe behaviours they have learnt about. The ***priority activities*** that would be needed to achieve this include:

a) Development of appropriate policies for provision of commodities (e.g. condoms) and services: Condoms are now available only to the married couples as a family planning method. The availability of condoms for prevention of STIs needs to be ensured, and access to condoms by all, irrespective of state of marriage, needs to be ensured.

b)Advocacy among different sectors for supportive environment: In order to enable adolescents to have easy access to information and commodities for preventing unsafe sex, advocacy at national, regional and local level needs to be undertaken so that policy makers, government's administrative infrastructure, civil society in general and

communities in particular are sensitized to the need for such information and/or commodities/services.

The ***key roles*** in implementing this strategy would be played by MOHFW. Other Ministries (e.g. Ministry of Information, Ministry of Religious Affairs) would play a supportive role by using their existing channels of communication to disseminate messages. NGOs would play a critical role by carrying out field level interventions.

3.5. Strategies for provision of easy access of all adolescents to ARH and other related services (objective 5)

3.5.1Introducing and expanding adolescent friendly health services

Besides appropriate information, the other most critical need is that of easily accessible ARH services by the adolescents. While married adolescents still have some access, the unmarried ones with STI or other reproductive health problems have almost no option for accessing services. The scale of ongoing interventions is miniscule compared to the overall needs. Even GoB's plan for introducing adolescent friendly services in selected MCWCs will have little impact.

The concept of adolescent friendly services is rather new to the country. Although few NGOs have experience in rendering such services, there needs to be greater capacity building on this and guidelines and tools for implementing partners need to developed. Besides offering such services from designated centres, implementing partners would have to find innovative ways of reaching out to adolescents who are marginalized or hard to reach.

The ***priority activities*** for realizing this strategy are:

a)Needs assessment and development of a national plan: There needs to be a thorough assessment of the existing services and the need to develop new services for adolescents. The process would be consultative, involving adolescents, their gatekeepers and the policy makers. Based on the needs assessment, a plan for developing such services across the country, and covering all different adolescent groups including the hard to reach and marginalized ones, would be developed. It would be efficient and effective if implementing partners are encouraged to develop services within the framework of this plan. This would avoid duplication and result in more effectiveness.

b) Capacity building for rendering of adolescent friendly health services: There needs to be an agreement on what is meant by adolescent friendly health services. The definition needs to be developed in consultation with the adolescents so that the service that is then put in place is responsive to their needs. Side by side, training materials and tools, job aides and BCC materials, guidelines and other technical support must be put in place.

c) Scaling up/introduction of adolescent friendly services in government/NGO service delivery infrastructure: Models of adolescent friendly services are already in place. These need to be scaled up and promoted to ensure optimal utilization by adolescents. Attention needs to be paid to the needs of the hard-to-reach and marginalized groups. Innovative strategies would be required for reaching these groups with accessible services.

3.5.2 Ensuring good quality of care in adolescent friendly outlets

This would be critical to ensure adequate utilization of the services. The ***priority activi***ties for ensuring this include:

a) Developing quality standards and guidelines: The assurance of an optimal standard of care in all outlets for such services would be critical for their optimum utilization. Service standards should be determined as part of defining adolescent friendly services and put in place in all new adolescent friendly service centres. Mechanisms to monitor the standards need to be put in place.

b)Recognition of centres providing good quality of care: Centres with best practices need to be recognized and rewarded to promote quality.

c) Establishment of referral and other supportive services: It is realized that adolescent friendly health services would also need to encompass many other supportive services which are not directly a part of 'clinical' reproductive health. Adolescents may need services related to violence, legal aid, and psychological counseling. For these specialized services, an effective referral mechanism would have to be established with specialized centres. If required, the facilities in such existing centres would have to be expanded to accommodate the increased need that could be potentially generated.

3.5.3. Promotion of adolescent friendly services:

Utilisation of services in adolescent friendly centres would depend to a large extent upon adolescents' and their guardians' knowledge about the existence of such centres, and their views/opinions about the centres. A well designed promotional campaign therefore

needs to be carried out, once the services are in place, for both adolescents as well as their guardians to inform them of the availability of services and encourage them to. Such campaigns will also generate wider social support for the adolescents to access such services.

The priority activities would include:

a) Designing and developing the campaign(s): This should be done on the basis of a qualitative research, involving both adolescents and their gatekeepers. The research should also determine which channels of communication would best be used for the purpose.

b) Implementing the campaign(s): The campaigns would need to be implemented according to a plan developed on the basis of research and should be comprised of both community and mass media based approaches.

c) Monitoring utilization of services in the adolescents friendly centres: A system needs to be put in place for recording and tracking the use of services in both the government and NGO/private facilities.

The ***key role*** in implementing this strategy would be again played by MOHFW. The technical expert organizations, including various UN agencies, selected NGOs and private sector specialized communication agencies with experience in working with adolescents, should pool their knowledge and experience to develop the implementing tools including assessment design and guidelines.

3.6. Strategies for creating favourable conditions which discourage risk taking behaviours among adolescents (objective 6)

3.6.1Mobilisation of adolescents and their gatekeepers against risk taking behaviours

A number of behaviours are seen among today's adolescents which jeopardize their life including reproductive life. These behaviours- drug abuse, suicides, gangsterism, violent behaviours, eve teasing, etc. – result from complex interplay of social, religious, cultural, educational and other factors. In order to successfully address these factors, which give rise to such behaviours, multi-pronged advocacy efforts targeted to the adolescents, their parents/guardians, teachers, leaders of communities they live in, and religious leaders need to be taken. Members of these and other groups need to be sensitized to the problems, pressures and tribulations of adolescents, the harmful behaviour that could

arise from these circumstances and the roles members of these groups could play to support the adolescents through their difficult times.

The ***key activities*** under this strategy therefore are:
a) Undertaking research to understand adolescents' risk taking behaviours and reasons behind them. An in-depth study or series of studies: with different groups of adolescents and their gatekeepers, including the marginalized and disadvantaged groups, would be undertaken. The study(ies), employing both qualitative and quantitative methods, should provide a clear understanding of the extent, types and reasons behind such behaviours, and provide the basis for identifying and designing appropriate interventions.

b) Development of a nationwide plan for advocacy with high-risk adolescents and their gatekeepers: Based on the findings of the above study(ies), adolescents groups at higher risks of developing such behaviours would be identified. Advocacy through workshops, seminars, etc would be organized to pre-sensitise these high risk adolescents and their gatekeepers on the adverse outcomes of such behaviours.

c) Involving media in developing awareness about these behaviours: Since the media has a wide and effective reach to the adolescents and their guardians, it would also need to be sensitized so that it can play a supportive role by publicizing these problems and generating understanding of the society in general about these problems. Orientation sessions with a cross section of the media would be held, a campaign involving all the different channels, which are favoured by adolescents, would be planned and implemented and through the media the communities and political and social leaders would be sensitized.

3.6.2 Supportive policies for reducing risk taking

To reduce the incidence and prevalence of risk taking behaviours, a favourable policy environment which would promote avoidance and condoning of such negative behaviours would be put in place. Appropriate clauses would be integrated within existing policies and, if required, new policies may be put into place.

The ***priority activities*** under this strategy would include:

a) Establishment of a special wing for adolescents in an appropriate ministry: There is no particular government body to oversee and protect the interests of the adolescents, as

there is for youth and women. Allocating this task to an appropriate ministry/department would provide a focal point that could initiate activities, oversee their implementation and be approached by adolescents or their gatekeepers.

b)Review of existing policies and incorporation of appropriate new policies/clause(s) in existing policies to prevent risk taking behaviours : Based on the findings of the research mentioned earlier, a comprehensive review needs to be undertaken and, through a consultative process with stakeholders, new policies/clauses need to be added or existing ones revised. Potential areas, which need to be addressed by these policies, include e.g. eve-teasing of girls, registration of early marriages by the marriage registrars, rehabilitation of rape victims etc.

c) Promoting treatment and rehabilitation opportunities: Opportuntiies for treatment and rehabilitation of victims of high risk behaviours (rape victims, victims of acid throwing or other forms of violence against women (VAW), drug addicts etc.) need to be expanded both in the private and public sectors.

The ***key role*** in this respect has to be taken by the Inter-ministerial Committee since a lot of the activities will need multi-sectoral collaboration and coordination. Different activities could be assigned to various relevant government/private departments and agencies under the leadership of this Committee.

Chapter 4
Implementation of the ARH Strategy

4.1 Leadership and Coordination

Implementation of the ARH Strategy would need concerted and coordinated action by a large and multifarious number of agencies. Several ministries (MOHFW, Ministry of Youth and Sports, Ministry of Education, Ministry of Primary and Mass Education, Ministry of Information, Ministry of Social Welfare) will be directly involved, while others will (Ministry of Home Affairs, Ministry of Law Justice and Parliamentary Affairs etc.)have to play a supportive role. In actual implementation of activities, in addition to the ministries and their agencies, departments and wings, NGOs and private sector enterprises will need to be involved. In some cases, involvement of individual experts, lawmakers and parliamentarians will be required. In order to coordinate these different kinds of agencies and individuals, and to ensure that activities carried out contribute to the achievement of the Strategy's objectives, a high level body working under the umbrella of a particular ministry would be required.

Given the close link of the ARH issue with MOHFW, the leadership for implementing the Strategy needs to be provided by the same Ministry. However, to ensure the commitment and ownership of other Ministries and agencies, and to coordinate their efforts, the existing Inter-ministerial Committee should be expanded. The Committee should be headed by the Joint Secretary (Development-Family Welfare) with senior level representations from other concerned ministries, NGOs, multi- and bi-lateral donors and

UN agencies. The Committee would have a well defined set of terms of reference to guide its activities.

The success of the Inter-ministerial Committee in carrying out its assigned tasks would depend on its having a strong secretariat. This secretariat would be situated outside MOHFW, housed in a competent agency, which would ensure that meetings of the Committee were held in time, meeting decisions were implemented timely, and the desired level of coordination and collaboration was being achieved.

4.2 Resource mobilisation

The resource envelope required to implement the policy needs to be estimated. The resource would represent a combination of funds to be drawn from the NGO Pool Fund, from existing budget in the PIP of MOHFW, and from bilateral grants to GoB/NGOs. All ARH related interventions, carried out by GoB/NGOs/others, should fall within the framework of this Strategy and should contribute to its vision and goal.