

Integration of Adolescent Sexual and Reproductive Health Programs in Health Facilities - What Works and What Does not: Evidence from Bangladesh

Sigma Ainul¹, Ashish Bajracharya¹, Ubaidur Rob¹

¹Population Council

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BACKGROUND

The adolescent population of Bangladesh is 29.5 million (14.4 million girls and 15.1 million boys), which is one fifth of the total population.

Unmarried adolescents are a vulnerable group who have far less access to information and services on SRH compared to their married counterparts.

Adolescent girls are extremely vulnerable, especially in the context of high child marriage and early childbearing taking place in Bangladesh.

Adolescents enter sexual life poorly informed about protection from pregnancy and infection, or their reproductive choices. Adolescent fertility in Bangladesh is among the highest in the world. Adolescents age 15-19 contribute one fourth of the total fertility in Bangladesh.

Identifying proper channels to reach adolescents with appropriate information and services is necessary to instill positive norms around contraceptive behaviors and to support safe and satisfying sexual and reproductive lives.

METHODS

The paper reviews 32 adolescent sexual and reproductive health (ASRH) programs in Bangladesh implemented in the last ten years (2005-2015), synthesizes lessons learned and suggests ways to integrate SRH programs in health facilities.

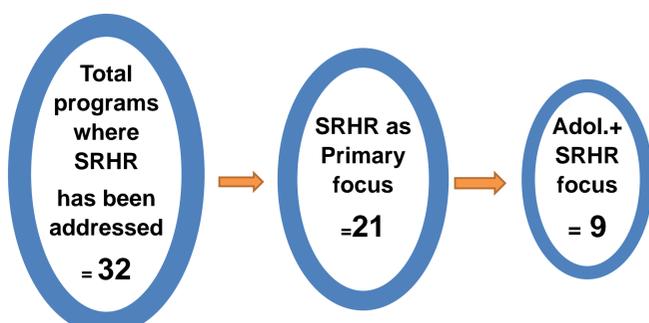
Methods include a desk review of research reports, publications, and programmatic information collection, cataloging of SRH programs in Bangladesh, and analysis of selected programs. Additionally, direct communication with program implementers and project site visits were conducted to better understand the program strategies and challenges and to identify components that work.

RESULTS

Lack of attention of SRHR programs on adolescents

SRHR is usually bundled up with other interventions such as, child marriage, family planning, livelihood, GBV, nutrition.

In most cases, adolescents were identified as in need of reproductive health programs because they were married. A targeted and tailored approach for reaching adolescents broadly was missing.



RESULTS

TABLE 1: DISTRIBUTION OF PROGRAMS BY AGE GROUP AND GENDER

Age group	Girl only	Boy only	Combined	Total programs
10-19	7	-	9	16
10-24	-	-	9	9
Mixed, between age 15 and 49	3	-	3	6
15-19, Married	1	-	-	1
Total	11	-	21	32

Programs are highly tilted towards girls

GIRL-ONLY PROGRAMS: 11

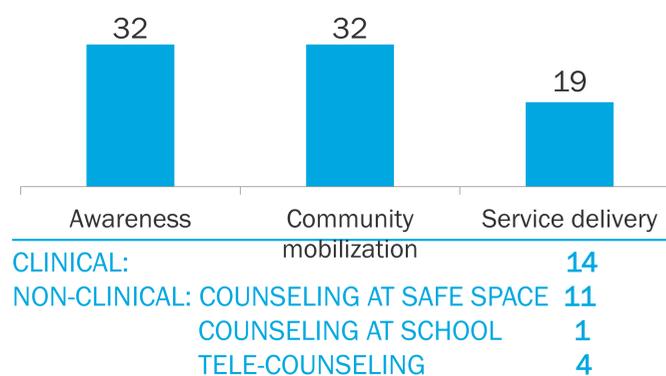
MIXED GENDER PROGRAMS: 21

BOY-ONLY PROGRAM: NONE

Only **2** programs targeted younger adolescents age 10-14

There is a lack of SRH services for adolescents, and WHILE available service provisions have not been able to reach adolescents adequately

FIGURE 1: DISTRIBUTION BY TYPE OF PROGRAM INTERVENTION



Clinical service points are labeled as "FP/Maternal Health Clinic" and serve all age groups together."

SUPPLY-SIDE BARRIERS:

- SRH service delivery still primarily revolves around married women (designed to provide antenatal checkups, delivery services, and family planning)
- SRH services for unmarried adolescents are still missing
- SRH services are clinically oriented, and opportunities for preventive interventions are frequently overlooked

DEMAND-SIDE BARRIERS:

- Adolescents are reluctant to visit health clinics that are viewed only as FP clinics.
- Perceived fear of stigma and discrimination

CONCLUSION

- Safe spaces for adolescents and information hubs in the community need to be linked with service delivery channels to impact with behavioral change and healthy transition to adulthood.
- Adolescents need to be integrated into regular services by making services adolescent friendly. Service providers need to be trained to provide adolescents' friendly services.
- Designated space marked for adolescent need to be set up in the existing health facilities; this would encourage adolescents to visit health service points and reduce the stigma associated with unmarried adolescents visiting an MR (menstrual regulation) or FP clinic.
- Working with Government and using existing health infrastructure will be more effective than the creation of parallel structures and fragmented efforts.
- More evidence is required on where adolescents would like to get services.

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SIGMA AINUL, Program Officer, Population Council, sainul@popcouncil.org

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