

Adolescent Friendly Health Corners (AFHCs) in Selected Government Health Facilities in Bangladesh: An Early Qualitative Assessment

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List of Acronyms

AFHC	Adolescent Friendly Health Corner
AFHS	Adolescent Friendly Health Service
ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
DDS	Drug and Dietary Supplement
DGFP	Directorate General of Family Planning
CBE	Clinic-Based Examination
CSE	Comprehensive Sexuality Education
EKN	Embassy of the Kingdom of the Netherlands
FGD	Focus Group Discussion
FP	Family Planning
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
MCWC	Mother and Child Welfare Center
MCH-FP	Mother and Child Health and Family Planning
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
NGO	Nongovernmental Organization
PNC	Postnatal Care
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UHFWC	Union Health and Family Welfare Center
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Union Parishad
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
VIA	Visual Inspection of Cervix with Acetic Acid

Executive Summary

Bangladesh has relatively limited experience providing adolescent friendly health services (AFHS); only a few NGOs provide services for adolescents, and these tend to be limited to sexual and reproductive health (SRH) awareness-raising activities and counseling on pubertal changes. To expand AFHS throughout the country and to extend SRH services to unmarried adolescents in particular, the Maternal and Child Health (MCH) Services Unit of the Directorate General of Family Planning (DGFP) in collaboration with development partners has started establishing Adolescent Friendly Health Corners (AFHCs) at selected government facilities at district and union levels.

Since the AFHC initiative is new in Bangladesh and no evaluations have been conducted of AFHS in the country context, understanding the implementation of the first phase of the AFHC program model will generate useful knowledge for improving and strengthening the program moving forward. With this in mind, and at the request of DGFP, the Population Council through the Evidence Project conducted a qualitative study of AFHCs to assess their performance and quality of services, and to generate evidence to inform the effective scale up of the AFHC model to additional facilities around the country. This report presents findings from a qualitative study assessing ten AFHCs, located in five Maternal and Child Welfare Centers (MCWCs) and five Union Health and Family Welfare Centers (UHFWCs) in Moulvibazar, Thakurgaon, Sirajganj, Patuakhali, and Cox's Bazar districts, all of which are supported by UNFPA.

KEY FINDINGS

Unmarried adolescent girls are using AFHCs. Global evidence indicates that integrating adolescent friendly services into existing health delivery systems is more effective than establishing separate or stand-alone youth and/or adolescent centers or clinics. The findings from this study support this, as it appears that AFHCs (which are integrated into existing facilities) are reaching unmarried adolescent girls with a range of health services, both general and SRH-related, through established health facilities.

It is also noteworthy that significantly few adolescent boys use the AFHCs and, when they did, service statistics indicate that they did so for general illness, rather than SRH services. Further exploration is needed to understand the reasons behind boys' lower attendance at AFHCs.

AFHC users expressed satisfaction with AFHC service providers. The adolescent girls who received services from AFHCs were generally satisfied with how service providers treated them. This is especially noteworthy, given the social stigma associated with unmarried girls seeking services from facilities that are often seen as 'family planning clinics' by parents and other community members.

Variation in the physical set-up of AFHCs impacts client access and privacy. There were some variations observed in the physical set-up of AFHCs at MCWCs and UHFWCs. In the MCWCs, each AFHC had a separate room or designated physical space. However, at the UHFWCs, only one out of five AFHCs had a separate room. Ensuring that a separate physical space is allotted for all AFHCs is important, since guaranteeing privacy for adolescent services and counseling is a critical aspect of quality adolescent friendly health services. This was noted by a number of respondents as a challenge, and some respondents and service providers also suggested separate waiting rooms for boys and girls, to further ensure privacy for adolescent clients.

Awareness of AFHCs is limited. Adolescents and parents had limited awareness of AFHCs. This may be because the AFHCs had just been recently launched at the time this study was conducted. However, more publicity and generating awareness about the centers in the community is recommended.

Awareness-raising efforts provide a unique opportunity to ‘rebrand’ how adolescent friendly centers are viewed — as sources of prevention and counseling services, and not just as treatment centers. These centers have the potential to be seen and serve as important ‘information hubs’ to serve a broad range of adolescent health and counseling needs.

AFHC users experienced challenges. While generally happy with the way AFHC service providers treated them, AFHC users described several limitations in accessing services at AFHCs. **Shortages of medicine** and **lack of privacy** are the major challenges identified by the adolescent respondents. The demand for **separate waiting rooms** for adolescents was also strongly emphasized by the respondents.

Concerns were raised by both clients and AFHC service providers regarding the **lack of behavior change communication (BCC)/educational materials** available in the AFHCs. These should include posters, booklets, and leaflets, and should address an expanded range of issues of concern to adolescents – e.g. mental health, substance abuse, early marriage prevention, and domestic violence.

Adolescent girls also requested **special service hours** for school-going adolescents, to extend the official service hours of 8:30 am to 2:30 pm. Afternoon service hours once a week or opening for weekend service hours could effectively create an enabling environment and maximize outreach to adolescents.

Service providers who are assigned to AFHCs face **difficulty operating in multiple places throughout their day** – outdoor service points to serve mothers and children and AFHCs to serve adolescents. The AFHS-trained providers talked about the additional demands created by their new responsibilities for serving adolescents, while continuing to meet the needs of their regular clients (mothers and children). This increased workload and the need to choose when to be in the AFHC was stressful for some providers.

Most service providers in MCWCs **used outdoor service points to serve adolescent clients** rather than using the designated AFHC, due to their workload. Service providers should be supported and motivated to use the AFHCs, so that adolescents can be confident that the service provider will be available when they come to the AFHC. It is also recommended that more service providers be trained in AFHS to increase availability of AFHS and to prevent service provider burnout. To address the challenge of service providers being required to deliver services in two different locations, it may be beneficial to examine clinic flow to identify additional opportunities to integrate AFHC into existing spaces, while ensuring privacy and confidentiality.

Chapter 1: Introduction

BACKGROUND AND RATIONALE

In Bangladesh, regardless of socio-economic status or educational background, open discussion about sexual and reproductive health (SRH) remains a cultural taboo, particularly for adolescents and young people, and particularly among unmarried adolescents. Most parents express discomfort discussing SRH issues with their adolescent children (Kumi-Kyereme et al. 2014). School teachers are also reluctant to discuss SRH issues with their students. As a result, adolescents in Bangladesh have very limited or no access to SRH-related information and services, and face serious barriers to getting information and guidance regarding SRH issues. Because they lack comprehensive access to essential information, very few adolescents are aware of their sexual and reproductive rights in Bangladesh (CAMPE n.d.).

Adolescents (10-19-year-olds) comprise more than one-fifth (14.4 million girls and 15.1 million boys) of Bangladesh's total population of 144 million (Population Census 2011). Adolescent girls tend to be more vulnerable to poor health, as they suffer from higher rates of malnutrition, early marriage, and pregnancy (Barkat and Majid 2003). Power imbalances in marital relationships compromises women's ability to exercise their reproductive rights, including decisions related to family planning, childbearing, and accessing maternal and child health services. This is even more the case for adolescent girls. A recent study conducted in southern Bangladesh described how child marriage results in early, mistimed pregnancies because young girls lack power and agency (Ainul and Amin 2015). Inadequate information, coupled with the traditional and conservative norms of Bangladeshi society, place adolescents, especially girls, at greater risk for unwanted pregnancies and increased vulnerability for STIs and HIV/AIDS (IPPF 2009).

Development partners and policymakers are increasingly advocating for comprehensive sexuality education (CSE) to improve adolescent health and wellbeing (WHO 2011; UNFPA 2014). CSE in and out of schools has been shown to be effective in a variety of cultural and socio-economic backgrounds in delaying initiation of sexual activity, reducing unintended pregnancy, and increasing use of condoms and contraception (Alford et al. 2003; Kirby 2001; and UNAIDS 1997). In addition to CSE, adolescents need increased access to SRH and other health information and services, to reduce the rate of adolescent and unintended pregnancy and to delay first birth. Globally, providing AFHS to ensure sexual and reproductive health and rights for adolescents has been hindered by both service providers' bias and stigma and other barriers experienced by adolescents (Svanemyr et al. 2015). Ensuring privacy and anonymity are key concerns for adolescents when receiving SRH services (WHO 2009). Confidentiality, respectful treatment, integrated services, culturally-appropriate care, free or low cost services, and easy access are all widely recognized as important components of appropriate services for adolescents.

There is increasing evidence about effective programming interventions to address adolescent sexual and reproductive health (ASRH) needs. In addition to CSE, there is strong evidence for adolescent friendly contraceptive service provision (Hinden et al 2012; HIP Brief 2015); youth friendly services (Zuurmon et al 2012); community-based outreach approaches (Hinden et al 2012); and social marketing (Van Rossem and Meekers 2002; Sweat et al 2012). Recent global consensus on ASRH approaches that are shown to be less effective and are therefore not recommended also inform programming (Chandra-Mouli et al 2015; HIP Brief 2015). In particular, evaluations show that peer education models and stand-alone youth centers have limited effects and are generally not recommended ASRH programming approaches.

Bangladesh has relatively limited experience providing adolescent friendly health services (AFHS); only a few NGOs providing services for adolescents and these tend to be limited to SRH awareness-raising activities and counseling

BOX 1**WHAT SERVICES ARE OFFERED AT AFHCs?**

Adolescent Friendly Health Corners (AFHCs) provide married and unmarried adolescent boys and girls (ages 10-19) with adolescent friendly information, counseling, and services on menstruation, RTIs/STIs, tetanus vaccine, anemia, safe sex, early marriage and pregnancy, contraceptives and family planning (to married adolescents only), gender-based violence (GBV), puberty, and substance abuse.

on pubertal changes. A recent review of adolescent SRH programs in Bangladesh by the Evidence Project/Population Council shows that, while some NGOs have begun to provide ASRH services, these programs have not been evaluated so their results and effectiveness have not been well-documented (Ainul et al 2017).

In Bangladesh, a large number of adolescents are sexually active due to high rates of early marriage, especially among girls, and are in need of a full package of SRH services, including contraceptive information and services, and maternal and child health care. Married women, including married adolescents, currently have access to these services through public sector Maternal and Child Welfare Centers (MCWCs) at the district and upazila levels, Union Health and Family Welfare Centers (UHFWCs) at the union level, and through public

hospitals at the district level. Unfortunately, unmarried adolescents do not have access to SRH information and services through these service delivery points. Furthermore, adolescents (and society in general) tend to view Government and NGO health facilities as “family planning clinics,” which creates a major barrier for adolescents to visit these centers for counseling and services. In addition, health services are often clinically oriented and opportunities for preventive interventions are frequently overlooked.

Provision of AFHS at public health facilities is a new approach in Bangladesh, started in early 2015 through the establishment of adolescent friendly health corners (AFHCs) with the financial support of several development partners. The MCH Services Unit of the Directorate General of Family Planning (DGFP) has been working with development partners to establish AFHCs at existing public facilities, to expand AFHS generally and to extend SRH services to unmarried adolescents, in particular. **Table 1** illustrates current partnerships between DGFP and development partners around the introduction of AFHCs at government facilities.

Additionally, Plan International Bangladesh, with support from USAID and EKN, has been working with DGFP and DGHS to expand the AFHS in 197 government service delivery points at MCWCs, UHFWCs and Community Clinics in Rangpur, Barguna, Kishoreganj and Khagrachori districts.

TABLE 1. AFHCs AT GOVERNMENT HEALTH FACILITIES

District	No. of Facilities	Supported By
Thakurgaon, Sirajganj, Cox’s Bazaar, Moulvibazar, Patuakhali	10 (5 MCWCs + 5 UHFWCs)	UNFPA
Khulna, Nilphamari, Bhola & Jamalpur	83 (4 MCWCs + 79 UHFWCs)	UNICEF
Meherpur	5 (1 MCWCs + 4 UHFWCs)	Save the Children
Kishoreganj, Barguna & Khagrachari	3 MCWCs + 26 UHFWCs	Plan International Bangladesh

Source: Adolescent Health Newsletter 2nd issue, November 2016.

These AFHCs are integrated into existing government health facilities, rather than constructed as separate stand-alone facilities. This integrated approach marks the AFHCs as a critical new initiative for expanding AFHS and reducing stigma and other barriers that adolescents – especially unmarried girls – face when seeking SRH information and services.

Since the AFHC initiative is new in Bangladesh and no evaluations have been conducted of AFHS in the country, understanding the implementation of the first phase of the AFHC program model will generate useful knowledge to improve and strengthen the program moving forward. With this in mind, and at the request of the DGFP, the Population Council through the Evidence Project conducted a qualitative study of AFHCs to document their performance and quality of services, and to inform the scale up of the AFHC model to additional facilities.

STUDY OBJECTIVES

The findings from this study fill an important evidence gap and can be used to increase the accessibility, use, and quality of ASRH information and health services provided through AFHCs. The overall objective is to strengthen the AFHC initiative to effectively meet adolescents’ needs and preferences. The key study objectives are as follows:

1. To assess unmarried adolescent girls’ experiences accessing information and services from AFHCs.
2. To explore unmarried adolescent girls’ perspectives on their health needs, the obstacles they face obtaining SRH information, supplies and services, and their preferences about how and by whom information and services should be provided.
3. To examine service providers’ perspectives and experience providing services to adolescents through AFHCs, identify challenges they face, and solicit their perspectives on how to strengthen service delivery.
4. To determine the perspectives of parents in the general community regarding adolescents’ access to SRH information and services, associated barriers, social norms, and opportunities to sensitize the community to increase acceptance of ASRH services.
5. To identify challenges and opportunities to strengthening service delivery through AFHCs, and generate demand among adolescents and support from the community for ASRH services.

INTERVENTION: ADOLESCENT FRIENDLY HEALTH CORNERS (AFHCs)

The AFHCs are intended to institutionalize SRH services for both married and unmarried adolescents at government facilities. This study focused on AFHCs supported by UNFPA in Moulvibazar, Thakurgaon, Sirajganj, Patuakhali, and Cox’s Bazar districts, as the first AFHCs to open (see **Table 2**). AFHCs, as noted, are not stand-alone health structures but are set up in existing UHFWC and MCWC facilities. These UHFWCs and MCWCs are already providing maternal and child health (MCH) and family planning (FP) services for mothers, children, and married couples; establishing AFHCs will extend SRH services to unmarried adolescents.

TABLE 2. AFHCs INCLUDED IN THE STUDY

Districts	Sl.	Location of AFHCs
Moulvibazar	1	MCWC, Sadar Moulvibazar
	2	UHFWC, Fatepur union, Rajnagar upazila
Thakurgaon	3	MCWC, Sadar Thakurgaon
	4	UHFWC, Gangnipara union, Haripur upazila
Sirajganj	5	MCWC, Sadar Sirajganj
	6	UHFWC, Rajapur union, Belkuchi upazila
Cox’s Bazar	7	MCWC, Sadar Cox’s Bazar
	8	UHFWC, Rashidnagar union, Ramu upazila
Patuakhali	9	MCWC, Sadar Patuakhali
	10	UHFWC, Pangashia union, Dumki upazila



MCWC, Thakurgaon. The AFHC Citizen Charter is shown on the left.

Physical Setup

An AFHC is defined as either a separate room or a dedicated space separated by a screen so that audio-visual privacy for the adolescent client can be maintained. AFHCs are designed to maintain privacy and confidentiality so that adolescent clients can share their problems openly with the service providers and can receive counseling and services. According to the government's AFHC protocol, if a separate room cannot be provided, a curtain will serve as a room divider to separate the

AFHC from the traditional services of the UHFWCs and MCWCs. It is hoped that the AFHC approach will improve privacy and confidentiality for the adolescent client. A marked signboard/citizen charter indicating the facility has an AFHC is placed in front of the facility to clearly display the SRH information and services offered at the AFHC.

As per government protocol, a standard AFHC should have a consultation room with two chairs and a table, and a designated waiting area for adolescent clients. There should also be a bookshelf displaying SRH behavior change communication (BCC) materials for adolescents to read on their own and a supply of BCC pamphlets that adolescents can take with them. However, supplying the AFHCs with all standard furnishings and materials was ongoing during the implementation of the study.



AFHC, Thakurgaon, MCWC



AFHC, Patuakhali, MCWC



AFHC, Sirajganj, UHFWC

Available Health Services and Service Providers

AFHCs are intended to serve as a hub for SRH information and services for both unmarried adolescent boys and girls. They are a place where adolescents can access information, counseling, and services on a wide range of ASRH issues. While the cultural context of Bangladesh and the policy of the Government of Bangladesh (GOB) does not permit the provision of contraceptives to unmarried adolescents, information and counseling on menstruation, RTIs/STIs, safe sex, early marriage and pregnancy, family planning, gender-based violence

(GBV), puberty, and substance abuse are to be provided to unmarried adolescents through these AFHCs. Services for unmarried adolescents are to include prescribed medicines for menstrual problems, RTIs/STIs, tetanus vaccine, and treatment of general health issues, including anemia. The information, counseling, and services that are being offered to unmarried adolescents through AFHCs are outlined in **Box 2**.

BOX 2

INFORMATION, COUNSELING, AND SERVICES PROVIDED AT AFHCs

Information and Counseling

- Physical and psychological changes during adolescence
- Food and nutrition
- Tetanus and other vaccines
- RTIs/STIs
- Menstrual cycle and hygiene
- Early marriage
- Reproductive health-related information and counseling
- Safe sex
- Contraceptives and family planning (to married adolescents only)
- Gender-based violence
- Substance abuse

Services

- Treatment for RTIs
- Menstrual problems and management
- Treatment of anemia
- Treatment for general health issues

The Medical Officer, Family Welfare Visitors (FWV), and Sub-assistant Community Medical Officer (SACMO) are the service providers at the AFHC. DGFP, with the assistance of development partners, organized a three-day capacity building training on AFHS for service providers of selected MCWCs and UHFWCs, which covered the following:

- Adolescent development and changes in adolescence (physical, emotional, behavioral)
- Sexual and reproductive health of adolescents
- Menstrual hygiene and menstrual cycle
- RTI, STI, and HIV prevention and treatment
- Prevention and treatment of anemia and malnutrition in adolescence
- Early marriage
- Risks of adolescent pregnancy
- Safe motherhood
- Risky social behavior during adolescence
- Substance abuse among adolescents, including prevention and treatment
- GBV

- AFHS
- Communication with respect, care, non-judgment, and non-discrimination
- Maintaining privacy and confidentiality and avoiding stigma
- Quality of services
- Maintenance of service registers and monitoring
- Service referral for complicated cases

Service Register and Referral

Each AFHC maintains a separate service register to collect basic demographic information (age, sex, marital status) and describe the services received by the client, subsequent visits, follow-up, referrals, and so forth, which enables the service providers to monitor continuity of services and ensure quality.

For complex or other services that AFHC service providers are unable to provide, adolescent clients are referred to higher-level medical facilities using a referral form. The AFHC service providers carry out subsequent follow-up after the referral.

STUDY SETTINGS

This study collected data from five MCWCs and five UHFVCs in five locations, for a total of ten AFHCs (highlighted in Figure 1), between August and September 2016. The five locations were selected by the MCH Services Unit of DGFP in collaboration with UNFPA to represent geographic diversity as well as variation in health and demographic indicators.

Study Locations

Moulvibazar is a district of Sylhet division situated in the north-eastern part of the country. This district is generally known for its tea gardens. The population is mainly Bengali, with a significant population from the Manipuri, Khasia and Tripura clans also living in the district.

Thakurgaon is a district in the north-west of the country in Rangpur division. It is bordered by Dinajpur district on the south, Panchagarh district to the east and India on the west and north. Agriculture is the main livelihood of residents in this district.

The Sirajganj district is part of Rajshahi division and also the gateway to North Bengal. The largest bridge in Bangladesh, spanning the Jamuna River, is situated here. The bridge has established strong links between the eastern and western parts of the country by both roads and railways.

MAP 1. FIELD LOCATIONS OF AFHCS



Cox's Bazar, located in the south-west part of Chittagong division, is on the Bay of Bengal. It is one of the most popular tourist destinations in Bangladesh, and tourism is one of the primary livelihoods in the district, along with fishing and seafood production.

Patuakhali, also located on the Bay of Bengal, is situated in the south-central part of the country in Barisal division. It is the main entry to the beach of Kuakata, and fishing and agriculture are the main occupations. Located along the same coastal belt, Patuakhali and Cox's Bazar are both affected almost every year by natural disasters like cyclones, floods and tornadoes.

TABLE 3. LITERACY RATE

Districts	Literacy rate (BDHS 2014)		
	Male	Female	Total
Moulvibazar	37.9	37.3	37.6
Thakurgaon	58.3	53.9	56.0
Patuakhali	59.6	52.5	55.9
Sirajganj	61.1	60.7	60.9
Cox's Bazar	47.7	47.5	47.6
National	47.4	43.7	45.2

Source: BDHS 2014 household member dataset. A person is considered literate if he attained beyond primary level education. Calculated among population aged 15 years or more.

TABLE 4. WEALTH INDEX

Districts	Lowest	Second	Middle	Fourth	Highest
Moulvibazar	29.3	21.4	17.9	14.0	17.5
Thakurgaon	20.0	10.6	17.6	28.2	23.5
Patuakhali	19.0	12.0	17.0	22.0	30.0
Sirajganj	10.9	8.3	16.1	26.6	38.0
Cox's Bazar	9.8	14.0	22.4	32.9	21.0
National	20	20	20	20	20

Source: BDHS 2014 household dataset.

TABLE 5. RATES OF MARRIAGE BEFORE THE AGE OF 18 (GIRLS)

Districts	Rate of Marriage Before the Age of 18
Moulvibazar	57.1
Thakurgaon	64.3
Patuakhali	78.9
Sirajganj	75.0
Cox's Bazar	61.5
National	59

Source: BDHS 2014 women dataset, derived using proxy indicator "age at first cohabitation" and calculated for 20-24-year-old women.

TABLE 6. CONTRACEPTIVE USE, 15-19-YEAR-OLDS (MARRIED ADOLESCENT)

Districts	Currently Using Any Method
Moulvibazar	29.2
Thakurgaon	50.0
Patuakhali	61.5
Sirajganj	61.1
Cox's Bazar	61.5
National	51.2

Source: BDHS 2014

Differences Between Rural and Urban Settings

All five MCWCs included in the study are situated in the heart of district towns in the five districts and are considered urban locations. Based on the study team's observations, these MCWCs had adequate communication and transport facilities from its other upazila towns. The study team noted that the areas served by these MCWCs had common features of urban settings, such as better access to health care services, education, housing, electricity, water supply, diversified work opportunities, administrative and business centers, and cultural hubs.

On the other hand, all five UHFWCs were in rural areas, with different infrastructure and physical characteristics from the urban settings of the MCWCs. It should be noted that the road conditions in these areas were good enough that the field research team did not experience difficulty traveling for data collection.

The study team also observed that in both urban and rural locations, the communities surrounding the facilities were heterogeneous in terms of socio-economic status, religion, education, and occupation. The livelihoods of rural residents were mostly associated with agricultural activities and small business, whereas people in urban areas had more diversified livelihood opportunities, ranging from day labor to business or salaried jobs. In both settings, internal migration, mainly among men, to other districts or upazilas for work was observed as a common livelihood strategy among low- and middle-income groups. Improved transportation facilities have enabled people at the union level to travel and work in nearby districts or upazilas on a daily basis.

STUDY METHODOLOGY

Data Collection

This study collected qualitative data through in-depth interviews (IDIs) and focus group discussions (FGDs). In addition, the study team used assessment tools to document the physical infrastructure and administrative aspects of individual facilities. Under the direct supervision of the study PI, four female and two male research assistants with education and experience in anthropology were trained and supervised in data collection activities in the five study districts. A five-day training on the data collection tools and qualitative methodology was conducted before starting the data collection. In addition, field tests of the IDI and FGD guides were completed before data collection commenced. All data was collected between August and September 2016. All IDIs and FGDs were audio-taped and transcribed into Bengali.

In-depth Interviews with Adolescents

IDIIs were conducted to collect information from unmarried adolescent girls (ages 15-19). To address the study objectives and incorporate wider perspectives, the study purposively differentiated unmarried adolescent girls into two groups- those who had received services from an AFHC and those who had not. In the remainder of the study report, these groups will be referred to as AFHC users and AFHC non-users. The main topics addressed in the IDIs are described in **Box 3**.

BOX 3

IDI Topics

Main topics of IDIs with AFHC users

- Common health concerns of adolescents
- Awareness about AFHCs
- Experience receiving services from AFHCs
- Quality of services
- Taboos associated with ASRH services and ways to sensitize communities

Main topics of IDIs with AFHC non-users

- Common health concerns of adolescents
- Reasons for not seeking services from AFHCs
- Ways to create demand among adolescents for AFHCs
- Taboos associated with ASRH services and ways to sensitize communities

A total of 30 IDIs were conducted with AFHC users and 20 IDIs with AFHC non-users across the five study districts. All interviews took place in the study respondent's household. Interviews lasted approximately 30-50 minutes and were audio-taped and transcribed into Bengali for analysis. As mentioned earlier, AFHCs have been set up in one MCWC and one UHFWC in each district (i.e. two facilities in each district). To ensure representation from each facility catchment area, three AFHC users and two AFHC non-users from each of the ten facility catchment areas were interviewed. Non-randomized, purposive sampling was used to identify AFHC users from the AFHC register maintained by the service providers. The research team collected names, addresses, and contact numbers of AFHC users from the register books (there is a specific column in the register book for home address and mobile phone number of the parents of adolescent clients of AFHCs). In most cases, the research team called the phone numbers to confirm whether adolescent girls visited the AFHC and requested to visit the household to identify adolescent girls for interviews. AFHC non-users were selected through community visits, during which the study team identified the adolescent population in the community and asked individually whether or not they used services from AFHC.

In-depth Interviews with Service Providers

A total of ten IDIs were conducted with service providers – one from each of the ten AFHCs in the five study districts. The providers in charge of the AFHC and who had received training on AFHS from the DGFP were selected for interviews. Interviews with service providers took place inside the facility and lasted 45-60 minutes on average. Interviews were audio-taped and transcribed into Bengali for analysis. The main purpose of these IDIs was to understand the service providers' perspectives on the common SRH concerns of adolescents, the type of adolescent clients seeking services from AFHCs, the challenges and barriers they face in providing health services to adolescents, and their suggestions for how to help them better serve adolescents.

Focus Group Discussions with Parents

A total of ten FGDs were conducted with the parents of adolescents from the community to understand their perspectives regarding the common SRH concerns of adolescents, and barriers and opportunities for adolescents' access to SRH information and services. The FGD guide specifically prompted discussion around: parents' awareness about the AFHC in their community; community perception about adolescents' sexual and reproductive rights and health-seeking behavior; barriers to adolescents' seeking SRH information and services; and community expectations of AFHCs.

Two FGDs (one with fathers and one with mothers) in MCWC at district level and UHFWC at union level were conducted around the catchment area of the AFHCs in each of the five districts. Participants were selected from the community through community visits, with an average of eight participants in each FGD. FGD participants were parents between 30-45 years old who were likely to have adolescent girls or boys at home or have raised an adolescent in the last five years. FGD participants were not parents of the adolescents who participated in the IDIs.

Facility Assessment of AFHCs

A structured facility assessment tool was used to observe the physical characteristics and infrastructure of the AFHCs. A total of ten facility assessments were conducted, covering each of the AFHCs included in the study. These assessments documented which services were provided to unmarried adolescents and which services were provided to married adolescents; whether services for RTI/STI identification and medication prescription was provided; and whether referral and monitoring mechanisms were available and functioning. In addition, the assessment tool described whether the AFHCs had an adequate supply of necessary commodities. During data collection, the study team randomly selected two register books from two AFHCs at MCWCs in two different districts to examine the service statistics and see how many married and unmarried adolescent boys and girls used the AFHCs and for what reasons.

Research Ethics

This study received ethical approval from the Institutional Review Board (IRB) of the Population Council and was also reviewed by USAID. Before commencing the IDIs and FGDs, data collectors followed approved procedures for obtaining informed consent from all respondents. For unmarried adolescent girls under age 18, adolescent assent and parental consent were also obtained. All interviewees gave their informed consent to being interviewed and to having the interview audio-taped. Research assistants clearly informed the respondents about the purpose of the study and the use of the data. All interviews were conducted privately. Procedures were also followed in data collection and management to ensure that the identity of respondents remained anonymous. This report uses pseudonyms for all respondents to ensure privacy; additionally, clinic locations and position titles have been omitted to ensure service providers anonymity. Written photo consent forms were also used to obtain permission to photograph service providers and adolescent girls.

Chapter 2: Results

Adolescents' Perspectives on AFHCs

INTRODUCTION

This chapter presents findings from IDIs with unmarried adolescent girls. These respondents were asked about their socioeconomic background, SRH problems and the concerns they experienced, treatment-seeking patterns for SRH problems and concerns, perceptions about and experiences at the AFHC, and their perception of the quality of services received. Interviewers probed to understand the extent to which the AFHC services provided unmarried adolescent girls privacy, and confidentiality and non-judgmental services.

DEMOGRAPHIC PROFILE OF ADOLESCENT GIRL RESPONDENTS

TABLE 7. RESPONDENT CHARACTERISTICS

	AFHC User	AFHC Non-user
Total number	30	20
Residence		
Rural (UHFWC at union level)	13	9
Peri-urban (MCWC at district level)	17	11
Age		
15-19 year	30	20
Education		
Currently studying	30	20
Education level		
Secondary (6-10)	23	16
Higher Secondary (11-12)	5	4
Tertiary	2	-
Religion		
Muslim	25	14
Hindu	4	6
Christian	1	-
Occupation of father		
Agriculture	4	4
Small business (entrepreneur)	10	5
Day labor	3	5
Service holder	4	3
Unemployed	3	-
Dead	3	-
Other	3	3

Among the 50 IDI respondents, 22 were from the nearby area of UHFWCs situated in rural areas and the remaining 28 were from MCWCs situated in peri-urban areas. All respondents were 15-to-19 years old. All were enrolled in an educational institution (school, college, or madrasa) at the time of the study, and the majority had completed secondary level education. Most participants were Muslim. The majority were from lower-middle income households, with mothers who were housewives and fathers who worked in agriculture, small business or as low-salary service holders such as salesmen at grocery stores, security guards, and so forth (see **Table 7**).

KNOWLEDGE AND ATTITUDES TOWARDS SRH ISSUES

Common SRH Problems and Concerns

The study sought to identify adolescents' common SRH problems, expressed in their own words. Adolescent girls reported problems related to menstruation –both irregular menstrual cycles and pain/cramping associated with menstruation. Concerns about white discharge were also commonly cited by this group.

“I experience severe pain during menstruation. I also feel discomfort that time which makes me wish better not experiencing menstruation.”

-Adolescent girl, 16 years old, Thakurgaon

“Some girls experience irregular menstruation and white discharge...Some girls experience lengthy menstruation and on the other hand some girls don’t experience menstruation at all...at this age girls are really shy and confused. They cannot decide what to do.”

-Adolescent girl, 15 years old, Sirajganj

Treatment Seeking Behavior of Adolescent Girls

Adolescent girls who reported experiencing SRH problems or concerns prior to the interview were probed about whether they had sought treatment and/or advice for the complaint, and if so, where they had gone. Girls reported that they first sought advice from female family members—in particular, mothers or elder sisters—followed by friends and neighbors. Girls also shared their problems with friends, primarily for their comfort, recognizing that their friends also lacked the necessary knowledge to solve their problem. Girls said that they do not discuss SRH-related problems with their father or other male members of the family. Overall, however, girls described a lack of reliable supports with whom they could share or seek advice related to SRH problems and concerns.

“There is barely anyone that we could talk to about our problems. We can talk to our mothers but not that much. There are friends that we can talk to but to a limited extent.”

-Adolescent girl, 17 years old, Sirajganj

“When girls face problems related to menstruation, they first discuss the problem with their close female friends. We cannot freely share the problems with mother and sharing or discuss with father is completely impossible. So we prefer friends and elder sisters.”

-Adolescent girl, 16 years old, Thakurgaon

One adolescent girl did report that another woman suggested she could go to a MCWC if she were experiencing health problems:

“I heard about the facility (MCWC) from a neighboring sister-in law. She had tumor in her uterus and took services from there. She was treated well there and suggested me to visit there if I face any health problems”

-Adolescent girl, 18 years old, Patuakhali

Embarrassment, Shyness, and Social Taboos

Embarrassment and feeling shy about seeking treatment was the most common reason for not seeking advice from a health facility or health professionals. Lack of family support, perceived social stigma related to a missed or irregular period, concern about poor quality of care, and lack of awareness about available services were also mentioned by many respondents.

“Discussing irregular menstruation is considered a forbidden issue, what people think if I discuss it! I wouldn’t freely tell service providers about my problem because these is not a normal issue to share.

-Adolescent girl, 16 years old, Thakurgaon

Although irregular menstrual cycles are common during adolescence due to hormonal fluctuations, the majority of adolescent girls interviewed reported problems related to perceived irregularities in their menstrual cycles (including concerns that cycles were too long or delayed) and to pain during menstruation. Many adolescents were hesitant to seek help in the case of delayed menstruation (real or perceived) due to the perceived stigma attached to a missed period, especially for unmarried adolescent girls. Even when an adolescent girl expressed her desire to see a doctor, she was often discouraged from doing so by her family members.

“I have heard that if any adolescent girl come to take service, people of community think she is pregnant or for any complicated problem. Even if the service providers go to houses people ask about the reasons”

-Adolescent girl, 17 years old, Thakurgaon

“People of the community ask ‘only married women come to this facility, you are unmarried why would you go there?’”

-Adolescent girl, 18 years old, Patuakhali

Adolescent girls also reported that trouble with menstruation is not always taken seriously by the family members whom they first consult. The family response creates the sense that these problems are “normal” and not to be discussed with anyone.

“Discussing irregular menstruation is considered a forbidden issue, what people think if I discuss it! I wouldn’t freely tell service providers about my problem because this is not a normal issue to share...Adolescent boys and girls wouldn’t talk to their parents about SRH issues. Even if they do talk to their parents, they will say, ‘that’s not a big issue...my mother asked me not to share my menstrual problem to a service provider. She said, ‘you will feel shy’. She (mother) asked to buy medicine from shop instead. But I was reluctant to take medicines because if I take medicine there is a possibility I might experience the pain again after some time.”

-Adolescent girl, 16 years old, Thakurgaon

Lack of Awareness of AFHCs and Perceptions of Poor Services at Government Facilities

While awareness of MCWC and UHFWC facilities was good, and adolescent girls visited those facilities for tetanus vaccination before the AFHCs were established, awareness of the AFHCs was very low among the respondents.

AFHC users were specifically asked how they learned about the AFHCs. The research teams were instructed to use the local term, if there was one, to describe the AFHC and to describe it in detail when asking the question - for example, “a clinic at the union/district where adolescents are provided services separately.” In most cases, respondents were not aware of the separate AFHC before going to the facility. The distinction between the mother and child center and the AFHC was not very clear to them until they visited the facility. Some respondents had heard about the AFHCs based on “word-of-mouth” from their peers who had visited the AFHC previously.

There is very limited public awareness about the opening of AFHCs, especially among adolescents (see Chapter 3 for more detailed discussion of the lack of community awareness). During interviews, a few adolescent girls mentioned the role of school teachers in raising awareness of AFHC.

“The center is beside my home, but I did not know about it. Couple of days back, I heard about it (AFHC) from our teachers and classmates. They visited the facility for attending a program”

-Adolescent girl, 17 years old, Thakurgaon

In addition to low levels of awareness, there was a common feeling in the study communities that Government facilities cannot maintain high-quality services, which led people to visit private facilities to obtain better treatment. This concern was shared by adolescent girls in the study:

“We think we can pay at a private clinic to get better service. We had doubts about service in a Government facility.”

–Adolescent girl, 16 years old, Moulvibazar

EXPERIENCES RECEIVING SERVICES FROM AFHCs

Adolescents were asked about their experiences receiving services from AFHCs, to better understand the factors associated with the AFHC initiative. None of the 30 AFHC users reported facing any obstacles or adverse situations when they visited the health facility to receive services, though there were some differences in their perspectives on specific aspects of the AFHCs.

Location of AFHCs

Most of the adolescents (both AFHC users and non-users) across the five districts described positive views regarding the physical locations of AFHCs, as the corners were situated within MCWCs and UHFWCs, which were perceived as generally accessible. MCWCs are located in the heart of district towns, and even people who live a far distance were able to get to the facility using available transportation. At the union level, community residents were able to travel to the UHFWC by foot or using local transport. Therefore, the physical location of the facility was not mentioned as an obstacle to visiting an AFHC.

Service Hours

Two different views were identified among adolescent girls regarding the service hours of the AFHCs. One perspective found the existing service hours (9:00 AM to 2:00 PM) to be convenient, as they could visit during breaks in the school day.

“The opening and closing time of the facility is convenient for me. It is situated beside my college so it only takes 5 minutes to get here. I visited the facility for taking service during the class interval”

–Adolescent girl, 17 years old, Sirajganj

However, another perspective was that the service hours were inconvenient, because they were in school or college and the facility was not open after they returned from their classes.

“The time is convenient for those who live in the house but those who go to school and college could not come during the service hour. I return from college at 3.00pm and if I want to visit then, I couldn’t.”

–Adolescent girl, 16 years old, Moulvibazar

Attitudes of Service Providers

Users of AFHC described cordial and friendly behavior from service providers when they visited AFHCs. A 16-year-old adolescent girl from Thakurgaon, visited the corner because she was concerned about white discharge. She reported being satisfied with the behavior of service provider:

“I was surprised by her [service provider’s] behavior. I didn’t feel any hesitation and she listened to my problem patiently. I liked the service because of her friendly behavior...She

[service provider] explained everything easily and precisely to me. That is why I liked their services...I was worried about how to speak about my problems. But when I started talking about my problems I wasn't scared anymore because she [service provider] was very friendly. She made me feel at ease to share my problem."

-Adolescent girl, 16 years old, Thakurgaon

Other adolescent girls shared similar sentiments:

"I felt like she [service provider] is my dear ones. She was giving me advice like someone who cares for me would. She advised me to take medicines and told me what to do. She listened to me seriously and behaved well."

-Adolescent girl, 16 years old, Thakurgaon

I shared my problem to her [service provider] freely. She was very good. She listened to problems carefully and I liked the way she talked with me. Now I know I can get mental support from the service provider if I share problem with her. I know, if I face health problems, I can visit the facility anytime and it makes me relaxed.

-Adolescent girl, 17 years old, Sirajganj

Privacy and Confidentiality

AFHC service providers are trained and required to maintain privacy and confidentiality while giving services to adolescent clients. Maintaining privacy was challenging and the study found different experiences at different AFHCs. In most cases, adolescent clients were satisfied that the service provider would ensure confidentiality and would not share their problems with anyone else. In some cases, respondents specifically mentioned that service providers ensured proper privacy.

"She [service provider] didn't let anyone in, as she was listening to me. A guy came from a medicine company but she asked him not to come, until she was done with me."

-Adolescent girl, 18 years old, Patuakhali

However, respondents also identified some crucial issues related to privacy. As the AFHC is situated inside the MCWC or UHFWC compound, patients coming for different types of services (e.g. maternal, child health, family planning, and general treatment) and other visitors share a common waiting space/room. Except at the Moulvibazar MCWC, there were no separate waiting rooms for adolescent clients. Adolescent girls also mentioned the need for a separate waiting room for them to ensure their privacy from the very beginning of their visit to the AFHC.

"I like the environment of the facility. The service provider was polite and calm...but I was feeling a little bit uncomfortable in the waiting room because medicine sales representatives of different pharmaceutical companies were entering that room frequently. I didn't feel comfortable in front of unknown persons."

-Adolescent girl, 16 years old, Moulvibazar

However, the research team also observed that service providers sometimes used the outdoor service points to serve adolescent clients, along with general clients. This practice was not appreciated by many of the study respondents, because it did not ensure privacy and respondents were worried about sharing their problems in front of other people.

“When I enter the room, there were other service providers who were providing services to other women. I felt uncomfortable because of their presence. I could not share my problem comfortably. They shouldn’t be there”

–Adolescent girl, 15 years old, Moulvibazar

RECOMMENDATIONS FROM ADOLESCENTS

Ensure Availability of Free or Low-cost Medicines

Adolescent girls (both AFHC users and non-users) shared a common expectation of receiving needed medicines free of charge from the AFHC. Government health facilities, including MCWCs and UHFWCs, distribute certain medicines free of cost to clients from lower-income groups. Thus, when adolescents from lower-income groups visited the AFHCs for services, they expected to receive medicine to immediately address their problem. However, during the interviews, many adolescents reported that they did not receive any medicine from the AFHC, and pointed to a shortage of medicine supplies at the facility level as the primary reason for this (see **Box 4**).

BOX 4

KASHPIA’S STORY

Kashpia (pseudonym), is a 16-year-old girl studying in class 7. Her father is elderly and unemployed. Her mother is a housewife. Her entire family (including her five siblings) is dependent on the income of her two elder brothers, both of whom drive rented motor vehicles. A week before she was interviewed for the study, Kashpia was suffering from leucorrhoea and lower abdominal pain and visited the AFHC with her elder sister to seek treatment. In her interview, she said that she was satisfied with the good behavior of the service provider and atmosphere of the AFHC. She said that the service provider listened to her problem carefully and prescribed her three medications. The medicines were not available at the facility dispensary, so the service provider suggested Kashpia buy them from a private dispensary. However, the medicines were expensive and Kashpia didn’t have enough money to buy them, so she returned home without the medicine. As a result, at the time of the interview, she still had not started taking the medicine. She concluded: “many girls like me are unable to buy medicines, it would be very useful if we can get medicine free of cost from the health facility.”

Improve Availability and Scope of BCC Materials

During the interviews, most adolescent girls noted, the lack of BCC materials at the facilities. They demanded different types of BCC materials, including posters, leaflets, and books, as well as an interest in a wide range of topics including early marriage and mental health issues.

“As for example if there were books in the adolescent friendly health corner about general health then I think people would like to read it. This will help the clients to learn about general health problems and also the time will be utilized. Suppose, clients will be able to know what to do when suffering from urinary tract infection and gain knowledge about cleanliness.”

–Adolescent girl, 15 years old, Cox’s Bazar

Address the Specific Needs of Adolescent Boys and Girls

During interviews, adolescent girls described the importance of meeting the particular needs of adolescent girls and boys. They talked about the need to have female doctors trained in AFHS on staff at AFHCs, to increase their comfort sharing their SRH problems.

“I have a good feeling about this initiative. One thing I would like to suggest that if there were female doctors then it will be easier to share our issues. We cannot share everything with male doctors, may be a few things but not all. That is why I feel a female doctor is much needed for female clients.”

-Adolescent girl, 16 years old, Patuakhali

Separate Waiting Room for Privacy

Adolescent girls strongly demanded a separate waiting room for ensuring their privacy. The research team observed that often service providers used the outdoor service points to serve adolescent clients, along with general clients. This practice was not appreciated by the adolescents, because it didn't ensure privacy. Adolescent girls shared that they felt discomfort during sharing their problems in front of other people.

“When I enter the room, there were other service providers who were providing services to other women. I felt uncomfortable because of their presence. I could not share my problem comfortably. They shouldn't be there”

-Adolescent girl, 15 years old, Moulvibazar

The need for separate waiting rooms for boys and girls was also highlighted as a recommendation for improving uptake of AFHC services:

“It would be better if there were separate waiting rooms for boys and girls. We just can't sit beside anyone.”

-Adolescent girl, 16 years old, Patuakhali

Alternative Service Hours

School- or college-going adolescent girls prioritized adding afternoon or weekend service hours to regular official service hours.

“More girls will be able to come if they (service provider) open the facility on Friday only for us.”

-Adolescent girl, 16 years old, Patuakhali

Chapter 3: Results

Knowledge, Attitudes, and Practices of AFHC Service Providers

INTRODUCTION

This chapter focuses on the perspectives and attitudes of service providers, specifically Family Welfare Visitors (FWVs) and Sub-Assistant Community Medical Officers (SACMOs) who are assigned to serve adolescent clients in the AFHCs. The main purpose of interviewing service providers was to understand their knowledge, attitudes and practices related to serving unmarried adolescent girls at the AFHCs. This chapter will specifically illustrate service providers' views on the common SRH concerns of adolescents, describe the type of adolescent clients

receiving services from AFHCs, describe challenges and barriers in providing health services to adolescents, and how to help service providers offer better care to adolescents (e.g., training, supplies, and community sensitization).

A total of ten service providers from ten AFHCs (five from MCWCs and five from UHFHCs) were interviewed for this study. See **Table 8** for an overview of the characteristics of service providers interviewed.

TABLE 8. DEMOGRAPHIC PROFILE OF SERVICE PROVIDERS INTERVIEWED

Characteristics	Number
Posted in	
MCWC	5
UHFHC	5
Designation	
SACMO	4
FWV	6
Gender	
Male	4
Female	6
Training on AFHC	
Received	9
Not received	1
Age of respondent	
23-40 years	2
40-50 years	7
> 50 years	1
Education (highest level)	
Secondary	7
Higher secondary	3
Total working experiences	
0-5 years	1
5-15 years	2
15-25 years	4
> 25 years	3

ADDRESSING SRH ISSUES WITH UNMARRIED ADOLESCENTS

Service providers at MCWCs and UHFHCs are accustomed to working with married women ages 15-49 years old. Although they have worked with married adolescents, the AFHC concept and service provision for unmarried adolescents is relatively new and quite different for them, and marks the first time they have been trained to provide ASRH services to unmarried adolescents. However, these service providers seem to have adapted well to this new role, and the discomfort and bias that has been described among these professionals when dealing with ASRH issues (e.g. school teachers) was not reflected in the voices of service providers during interviews.

Training of Service Providers

Before the AFHC programmatic intervention was launched, ten service providers from selected facilities received training on adolescent health

from the MCH Services Unit of DGFP. Nine out of the ten service providers received a three-day basic training on AFHS in Dhaka during May-July 2015. One service provider missed the training due to illness. All service providers reported that the training was useful for them because over the course of their careers as FWVs or SACMOs, they had received a number of trainings related to a variety of health issues (antenatal care, postnatal care, VIA, CBE, emergency obstetric care, STI/RTI, MR, MRM, FP, and so forth), but had not received specific training focused on AFHS. All of the service providers described the training on adolescent health as adding value to their professional career.

“In the training sessions we were taught how to discuss SRH related issues with the adolescents. Every 10- 19 year old boy and girl go through both physical and mental changes during puberty. Girls start menstruating and boys experience wet dreams. These changes are normal and natural. So we assure adolescents not to worry about these. We suggest them to maintain hygiene and cleanliness during menstruation. All of these issues were discussed in the training.”

-Service provider, Moulvibazar

The interviews sought to assess the impact of training on the service providers’ knowledge, skills, and capacity to serve an adolescent and youth population through ensuring a friendly and comfortable atmosphere. The remaining sections of this chapter will discuss different aspects of service provider’s knowledge, attitudes and practices related to their work at AFHCs.

Service Providers’ Perspectives on Common ASRH Problems and Concerns

Most of the service providers identified common SRH problems of adolescent girls who visited AFHCs, including menstrual cramps, abdominal pain, little or excessive bleeding during menstruation, white discharge, irregular menstrual cycles, vaginal infections, and urinary tract infections. In addition, many adolescents also visited the AFHC for malnutrition, anemia, social or family relationship problems, weight loss or weight gain. While the SRH problems that prompted girls to seek services from AFHCs were wide-ranging, service providers also used visits to address a wide range of issues and advice.

“Generally adolescents come to me with menstrual cramps, excessive bleeding, itch, white discharge, amenorrhea, malnutrition, anemia etc. If I have adequate medicine in my stock I give them for free. If we don’t have medicine in stock, I suggest them to buy the medicines from outside. I try to distribute as much folic acid and iron supplement as I can among the adolescent girls. I suggest girls to use sanitary napkins and ask them to dump the pads under the soil. I tell them to have nutritious food during puberty”

-Service provider, Moulvibazar

Service providers also differentiated the health problems of married and unmarried adolescent girls. According to one service provider:

“Most of the unmarried adolescents come to us with leucorrhoea (white discharge) and malnutrition. In contrast, married adolescents come to us for taking advice on contraception for birth spacing.”

-Service provider, Cox’s Bazar

Service Providers’ Treatment of Adolescent Clients

Establishing effective communication with adolescent clients is one of the main requirements for ensuring quality service. During the interviews, all service providers mentioned that after receiving the training their confidence level in dealing with adolescent clients had improved significantly.

According to the service providers, respectful and friendly behavior with clients throughout the visit is essential for ensuring quality care. They also mentioned that they have to treat unmarried adolescents more carefully than married adolescents.

“Married adolescents talk easily and openly with us about their problems but unmarried adolescents feel shy. We have to be more friendly with unmarried adolescent to make them relaxed.”

-Service provider, Cox’s Bazar

“I need to behave friendly so that she could trust me and be assured that her privacy and confidentiality is maintained. If I disclose my client’s problem to others then her confidentiality is breached. As a result she would lose faith in me.”

-Service provider, Thakurgaon

Ensuring Privacy and Confidentiality

AFHC service providers received specific guidelines about the significance of ensuring privacy and confidentiality of adolescent clients. During the interviews, service providers were asked how they ensure basic privacy and confidentiality for adolescent clients.

“If any adolescent comes with SRH problem, I take her to a different room with door, window and curtains to ensure privacy. No one could see anything. I also talk quietly with the client so that no one can hear our discussion from outside”

-Service provider, Moulvibazar

“I do not share one’s problem to others. If the client comes here with someone, I ask them to sit outside. I take all the information of the client at first and then try to solve their problems. Medical ethics also give emphasis on client privacy.”

-Service provider, Sirajganj

Age-appropriateness

Providing age-appropriate information and services to adolescent client is considered one of the crucial aspects of AFHS. Service providers should have proper understanding of age-appropriate services, such as when to give information about menstruation, puberty, safe sex, or FP.

About Menstruation

Service providers emphasized the importance of providing information on common aspects of menstrual management to adolescent girls, starting around age 10 years.

“I think we should start talking to girls about menstruation from 10 years of age. It is because most of the girls experience their menstruation from 10-12 years.”

-Service provider, Patuakhali

“I think we can talk to them about menstruation from the age 10 years because adolescent boys and girls are matured for their age now a days. Adolescents have easy access to television and mobile phones by which they are exposed to the idea of intimate relationship of adults, specially pornography and getting influenced in early sexual encounters.”

-Service provider, Thakurgaon

About Safe Sex and Family Planning

Different opinions were observed among service providers about when adolescents should receive information about safe sex and FP or contraception.

“We should talk to adolescent before their marriage about reproductive health. I think the age 16-18 years is appropriate to talk about safe sex and family planning. If we talk to younger girls who haven’t experienced menstruation about those issues, then talking to her would be useless as she is naïve about these issues at that age.”

–Service provider, Moulvibazar

“The early marriage rate is higher here. If we talk to them about SRH issues at the age of 15/16 years, that wouldn’t be appropriate because many girls are being married off at the age of 13/14 years. We should start providing normal SRH knowledge to adolescent girls immediate after the menstruation starts. For me 13-14 years is the perfect age for both boys and girls to discuss about safe sex and importance of family planning”

–Service provider, Patuakhali

As part of the service provider IDIs, the interviewer shared a vignette to elicit the provider’s response as to the approach and services they would provide to an adolescent for irregular menstrual cycles. **Box 5** describes the vignette and some selected responses of service providers for unmarried and married adolescent girls.

BOX 5

RESPONSES OF SERVICE PROVIDERS ON IRREGULAR MENSTRUATION

Vignette

Farida is a girl of 16 years and she has been having trouble with her regular menstruation. According to Farida, she experienced her last menstrual cycle almost 8 weeks before. She is very shy and is unable to express her situation properly. She came to the AFHC with her mother. How would a service provider make her feel comfortable? What sort of services will you provide to Farida?

Service provider, Moulvibazar

“At first I will let the client in and tell her to sit down. When she opens about her problem (irregular menstruation) then I will tell her not to worry. I will try to carefully identify the problem. Unmarried adolescent girls can experience irregular menstruation cycle for different reason. I will talk to her friendly like her family member. If she is suffering from irregular menstruation then I will first prescribe her to take iron supplements. Besides, I will suggest her to take nutritious food. With the nutritious diet she will recover from her deficiency of blood.”

Service provider, Sirajganj

“I will do tests for her hormonal imbalance. Sometime girls suffer from irregular menstruation for anemia. I will assure her there is nothing to be worried about and treat her accordingly.”

SERVICE PROVIDERS' BARRIERS AND CHALLENGES

Service providers identified some particular barriers and challenges they face when dealing with adolescent clients at AFHCs. In most of the cases, the challenges were part of the larger infrastructure and administrative processes of the facility.

Balancing Previous and Newly Assigned Roles

“Suppose I am busy in delivering a baby and an adolescent comes to take service. Which one should I choose? I cannot leave the delivery room. I could also be busy in VIA test. So it would be good if all the service providers can get the training. Then in my absence, another SP can provide services to adolescents.”

-Service provider, Thakurgaon

All five FWVs at MCWCs who received training and provided services to adolescents said that they faced difficulties managing their previous roles and newly assigned AFHC roles. As mentioned earlier, only one FWV from each MCWC received capacity building training on AFHS. On the other hand, two service providers (the SACMO and FWV) at each UHFWC received training. The MCWC is the most well-resourced district-level public facility, offering hospital-based services for maternal and child health and family planning (MCH-FP) and general health services, and is therefore very busy. During the study, it was found that in a regular day (9:00 am – 2:30 pm) approximately 40-60 clients visit the MCWC for MCH-FP services. On average, 30-40 normal deliveries take place each month at the MCWCs, and FWVs assist the medical officer in most of these deliveries. The regular job responsibilities of FWVs also include providing postnatal care (PNC), antenatal care (ANC), and general health services; assisting with cesarean section; distributing oral pills and condoms; visual inspection with acetic acid (VIA) screening test for cervical cancer; insertion of IUDs and providing health education. Some service providers noted that, given these many responsibilities, managing their workload was challenging and sometimes creates obstacles to providing services at the AFHC. On the other hand, service providers at the UHFWC have a lighter workload than the MCWC service providers, and they did not identify any adverse impact of their regular responsibilities on their newly assigned AFHC roles.

Workload and Lack of Staff

Related to the challenge of balancing new roles with existing responsibilities, another common theme in interviews with service providers was the feeling that human resources were inadequate at the facility level. Service providers said they face serious obstacles to ensuring regular MCH-FP services at MCWCs or UHFWCs due to lack of staff.

“We are facing serious problems for lack of staff to ensure the regular services. There is no pharmacist, no family planning officer in my facility. There are posts empty for volunteers too. We don't need new posts, just ensuring posting in the empty posts will be enough.”

-Service Provider, Cox's bazar

“Government should increase staffs at our facility and also give training to them on adolescent health. Even if they (government) cannot allot more staff, then other available service providers should receive training on AFHC. Then they will be able to provide service to adolescents when we are busy.”

-Service Provider, Thakurgaon



AFHC, MCWC Cox's Bazar

Shortage of Medicine Supply

Service providers also described a critical shortage of drug and dietary supplement (DDS) supplies, although they did not know the reasons for the shortages. UHFWC service providers said that their inability to provide medicines to clients is the main cause of declining overall general client attendance. MCWCs were in a better position; although they did not receive all required medicines, service provision was possible. However, the study team found that all facilities (UHFWCs and MCWCs) had sufficient supplies of family planning commodities and delivery kits.

Service providers also noted that adolescent clients frequently need general medicines such as iron tablets and folic acid. To ensure better health service from AFHCs, additional supplies of these medicines should be allotted to AFHCs.

“Most of the adolescents suffer from malnutrition. I suggest them to take nutritious food. But they also demand iron supplement and another vitamins supplements. But I cannot provide it because of shortage of medicine.”

-Service Provider, Cox's Bazar

“We need logistics and medicine, so that we can provide people with services as well as medicines. If we could distribute iron tablet and other medicines then people would be eager to visit this facility.”

-Service Provider, Moulvibazar

Separate Waiting Room for Adolescent

“Talking openly about sexual and reproductive issues is very difficult in our society. Sometimes women come to me and ask me not to disclose her visit to her brother and father as they would get angry. Girls contemplate coming here without letting neighbors and others know. Girls ask us not to disclose her visit to anyone from her locality. They often want to talk to us in a different room.”

-Service Provider, Cox’s Bazar



Adolescent client at outdoor service point, Cox’s Bazar

The importance and need for a separate waiting room for unmarried adolescent girls to ensure their privacy was consistently mentioned in service provider interviews. Across the country, many people hold conservative attitudes towards ASRH needs. If an unmarried adolescent visits a UHFWC or MCWC, some people might associate it with a pregnancy or miscarriage, which could have negative ramifications for her image and future marriage options. One service provider expressed the importance of a separate waiting room for adolescents in the following way:

“In the common waiting room, an adolescent girl may not feel at ease. Many types of clients come to us every day and wait until we provide service. Suppose an unmarried adolescent girl comes to me for service and later someone who waited for service could spread rumor that this girl had physical problem so that she visited the facility. I cannot control it if it happened. If there is a separate waiting room for adolescents, they can sit there alone and can chat with each other freely about their problems. It would also be useful for us to treat them separately away from married women.”

-Service Provider, Sirajganj

While the need for separate waiting rooms was clearly described, the lack of rooms for existing services at UHFWC was also identified as a significant barrier to be addressed:

“We do not have any extra room which we could use as AFHC. Even we don’t have a store room. There is a post for assistant surgeon although he does not come but there is no room available for the doctor. So how could we manage a separate waiting room and separate service point for adolescent?”

-Service provider, Patuakhali

Challenges in Using the AFHC as a Service Point

Service providers reported challenges related to the physical space and set up of the AFHCs, with implications for their regular work flow and service delivery as well as their ability to offer AFHS.

MCWCs have outdoor service points, and it emerged during the study that both general clients and adolescent clients (both married and unmarried) wait in the same line to receive care at the outdoor service point. While this situation might be acceptable for many general clients, for the reasons mentioned above, adolescent clients should ideally be treated separately at the AFHC by a service provider who has received specialized training. However, this requires service providers to shift from one space to another throughout the day, which may not be possible, particularly with high patient loads. When this scenario was discussed during the interviews, one FWV from an MCWC replied:



Outdoor service point, MCWC Cox's Bazar

“When I serve general patients in the outdoor, then I cannot serve married or unmarried adolescent in another room simultaneously. If I wish to serve the adolescent client in a separate room, it can be possible for one or two times but other clients will not allow me to do that frequently. It might even cause chaos. If another service provider take charge of the AFHC, only then adolescent clients can receive special service.”

-Service provider, Cox's Bazar

Another MCWC service provider said:

“I used to sit at one place and now I have to sit in two different places. I also have to maintain two different registers.”

-Service Provider, Patuakhali

Another issue, more common for UHFWCs than MCWCs, was the lack of space at some facilities for a dedicated AFHC. The team observed variation in the number and condition of the rooms allotted for the AFHCs among the UHFWCs in the five study districts. For instance, in Fatepur UHFWC, Moulvibazar, AFHC services had not yet started at the time of data collection, but the storeroom had already been renovated for use as the AFHC. Similarly, in Sirajganj, the doctor's room (which had not been used by the doctor for years) was renovated for use as the AFHC.

On the other hand, in the UHFWCs situated in Dumki, Patuakhali; Haripur, Thakurgaon; and Ramu, Cox's Bazar, there were no empty or unused rooms that could be used as the AFHC. In these cases, the existing FWV and SACMO rooms were upgraded by restoring the water filter, adding a new chair and table, file cabinet, clock, and weight and height scale to ensure an adolescent friendly atmosphere. The following statements describe the inadequate physical spaces at some UHFWCs:

“We are unable to set up AFHC in a separate room. Mainly this facility is designed for providing service to mothers and children. That is why I have decorated my office room with the allotted materials for AFHC- water filter, weight and height scale and clock. I provide services to adolescents from my room.”

-Service provider, Pangashia, Patuakhali

“We don’t have separate room for AFHC. I and my FWV colleague normally see the patients on a first come first service basis. We do not have extra staff who could maintain the serial number of patients. That is why I have arranged the seating area in a way that the patients can receive service according to their entry to the facility.”

–Service provider, Ramu Cox’s Bazar

Inconvenient Service Hours

The official service hours of all MCWCs and UHFVCs are 8:30 am to 2:30 pm. At present, functional AFHCs maintain the same service hours. In addition to daily service hours, these facilities offer 24-hour normal delivery service, provided by the residential FWVs. There were opposing views among service providers regarding the most suitable timing of service hours for the AFHC. Some service providers identified the regular service hours as inconvenient for school-going adolescents:

“The AFHC starts at 8.30 am and closes at 2.30 pm. It is not a convenient time for adolescents because they have school from morning to noon.”

–Service provider, Moulvibazar

“The outdoor service opens at 9.00am and ends at 1.00pm. During the period huge number of general clients for MCH-FP services visit the facility. If any adolescent come then, we faced difficulties to provide them service separately. I think it would be useful if we can dedicate a different service time for adolescent. Afternoon would be convenient then because adolescent could visit us on the way to return home from school or college and we will also have free time for them.”

–Service provider, Patuakhali

Communication Between Parents and Adolescents

According to some service providers, communication on SRH issues between parents and their adolescent children exists but is hampered by many socio-cultural challenges. In their opinion, most parents feel uncomfortable discussing SRH issues with their children. One service provider said:

“Very few parents often talk to their children about sensitive issues like physical and mental changes during puberty and menstruation. Normally children cannot discuss about these with fathers at all. Most of the adolescent girls and boys share their problems with their mothers.”

–Service provider, Sirajganj

Service Statistics of Randomly Selected AFHCs

As part of our data collection, we randomly selected two MCWCs and reviewed their AFHC client register book to get a sense of how many adolescent boys and girls, both married and unmarried, were using the AFHCs and for what purpose. Among adolescent girls seeking services from AFHCs, 75% were unmarried. Only 2.5% of adolescents using these two AFHCs were boys. The service statistics also show that the majority of these AFHC clients (almost 78%) sought services to address general illness concerns such as fever, nasal congestion, cough, diarrhea, and so on (see **Table 9**).

TABLE 9. AFHC SERVICE STATISTICS, JANUARY–SEPTEMBER 2016

AFHC Location	Total number of adolescents (age 10-19)	Girls	Boys	Married Girls	Unmarried Girls	Reasons for Visiting AFHC		
						General Illness	SRH issues	ANC/PNC
Patuakhali MCWC	380	373	7	135	245	255	70	55
Sirajganj MCWC	348	337	11	46	302	309	37	2
Total	728	710	18	181	547	564	107	57

RECOMMENDATIONS FROM SERVICE PROVIDERS

Designated Service Provider for Adolescents

In order to ensure intensive services for both married and unmarried adolescent clients, most of the service providers strongly recommended assigning one FWV to the AFHC, who would not leave for other duties during the AFHC service hours. One provider articulated the issue quite specifically:

“If we want to attract adolescent client for visiting AFHC, we have to ensure one FWV at AFHC for round-the-clock. At present my only FWV colleague ensures at least eight times satellite clinic outside from facility each month in different villages. These eight days adolescent will not find her in the facility during the service hours. Rest of the working days when she works at office, she serves many pregnant women and distribute contraceptives also. Although I give advice on family planning but as a male service provider, I am unable to provide intensive service to the adolescents like a FWV does.”

–Service provider, Moulvibazar

Introducing Registration Cards for Unmarried Adolescents

All adolescents receiving services from the AFHC are registered in a separate register book. Married adolescents who are pregnant, receiving FP, tetanus vaccine, or ANC-PNC service currently receive a registration card with a unique serial number. However, there is no such registration card for unmarried adolescent girls or boys who attend the AFHC for either general or SRH-related services. Some service providers suggested introducing a separate registration card for unmarried adolescents, which would help track specific adolescent clients who visit the AFHC.

BCC Materials and Campaigning

Although a citizen charter about AFHCs was observed in every facility, no specific posters, brochures, leaflets or flip charts for adolescent clients were seen during the data collection period. Demand for accessible BCC materials for adolescent clients, such as take home leaflets, was expressed by service providers.

“We need leaflet, flip chart and also adequate supply of medicine to ensure proper health care service of adolescents. If we have pictorial flip charts, we could practically show them the problems and solutions. It would also be good if we could distribute leaflets among the adolescents”

–Service provider, Moulvibazar

Some service providers also mentioned specific campaigning strategies to popularize the corner, such as:

“We can inspire people to come here by posting advertisement on newspapers, television and banners. We could also arrange meeting with local people to let them know about SRH issues and service provision of our facility.”

-Service provider, Sirajganj

“If we could set up billboards in busy points or in front of different schools then adolescents would know about AFHC and its service provision.”

-Service provider, Patuakhali

The importance of designing age-specific BCC materials for adolescents was also identified by some service providers:

“We have some leaflets against child marriage and early pregnancy but we don’t have take home BCC materials for adolescents. I think age appropriate leaflet would be more useful for adolescents.”

-Service provider, Cox’s Bazar

Collaboration with Local Schools to Increase Awareness

There was a common view among service providers that education and health have a positive relationship. They reasoned that if adolescents are provided health education, they will be more aware about their own SRH, which in turn will improve their overall health. Therefore, providers felt that collaborating with educational institutions to provide health education would be an effective way to reach a large number of adolescents in a systematic way. Several providers raised this suggestion when asked to share their views on how to generate demand for AFHC:

“I think it will be very fruitful if we could engage schools. There are a lot of students in a school and if we visit schools then we will be able to reach lots of adolescents at a time. Many adolescents cannot even talk to their parents about their problems. If we work with schools, these group of adolescents will be benefited.”

-Service provider, Thakurgaon

“We could introduce creative approach for awareness campaigning on SRH issue. For instance, in a national observation day with the support of school teacher, we can organize essay writing competition on SRH issues. Through the process we could also disseminate information about AFHC. Each school can organize such event.”

-Service provider, Cox’s Bazar

Involving Local Leaders and Other Gatekeepers

Most service providers believed that community mobilization involving a variety of stakeholders, such as UP chairmen, UP members, religious leaders, teachers, parents, business persons, cultural personalities and representatives from NGOs, would help generate support and demand for AFHC among the community.

“High profile stakeholders from the community need to get involved in this. If religious leaders are involved then many people can know about this. Local political leaders, representatives from every sector should be associated with this. Everyone should know the importance and significance of SRH issues.”

-Service provider, Fatepur Moulvibazar

“I think if UP chairman and women member of the union council speak about AFHC in different public gathering then that would be very useful. Even, school teachers can play the most vital role by disseminating information about the corner among their students.”

-Service provider, Cox’s Bazar

Involving Parents

Service providers strongly recommended involving parents in generating demand for AFHC. Most providers mentioned that both adolescents and parents feel uncomfortable discussing SRH issues with each other. Providers suggested that this communication gap can be addressed by raising awareness and imparting knowledge among the parents and elders in the community. It was suggested that this awareness creation could be integrated into providers’ regular interactions with parents and elders.

“Many men and women come to us for taking general and reproductive health services, we could tell them about the importance of adolescent health. We could also tell them about our AFHC. Then they will spread information of the corner among other people of the village by saying that adolescents can get sexual and reproductive health information and services from the corner free of cost. Through the process, many parents will also come to know about the corner.”

-Service provider, Cox’s Bazar

Involving Field Level Staff

Most service providers recommended involving field-level staff in publicizing the AFHC among the community, especially FWAs, who visit door-to-door to provide family planning (FP) services. According to one service provider:

“We have one FWA for each ward. They go to door to door for family planning services. They know every household of their catchment area. Therefore, they can act as the primary sources who could inform people in the community about AFHC.”

-Service provider, Moulvibazar

“If we could involve all the field workers of family planning in promoting AFHC then I think it would be very effective.”

-Service provider, Patuakhali

Chapter 4: Results

Perspectives of Parents

INTRODUCTION

This section highlights the findings of FGDs conducted with the parents of adolescents. Irrespective of socio-economic status, parents and adult family members should be a key source of support for adolescents facing SRH problems. They are also expected to observe their adolescents' activities on SRH issues, as well as share SRH information and awareness of services with them. This study sought to understand the knowledge and attitudes of parents regarding the SRH issues of their adolescent children. The main purpose of the FGDs was to understand community perspectives on adolescents' access to SRH information and services and associated barriers, social norms, and ways to sensitize the community to increase acceptance of ASRH services. The FGDs explored parents' perceptions about adolescents' right to have such information and services, and associated socio-cultural barriers. The FGDs revealed parents' preferences and reservations about AFHCs for the provision of SRH services and information. They also explored parents' opinions about how to create demand among adolescents for AFHCs, and how to create a conducive environment in the community that minimizes taboos related to ASRH services.

PROFILE OF THE PARENTS

A total of ten focus group discussions (FGDs) were conducted in five districts - Moulvibazar, Cox's Bazar, Patuakhali, Thakurgaon and Sirajganj. In each of the study areas, one FGD with mothers and one FGD with fathers was conducted, with different FGD guides for mothers and fathers. The study also ensured equal distribution of FGDs in both urban and rural localities. A total of 85 parents (39 female and 46 male) who had at least one unmarried adolescent child participated in the FGDs. Participants were selected randomly through transect walk in the catchment area of facilities where AFHCs are functioning. The majority of female FGD participants were between 35 to 45 years old, and the male participants were mostly between 45 to 55 years old. Most FGD participants had limited education, with very few having completed secondary education (see **Table 10**).

PARENTS' KNOWLEDGE AND ATTITUDES ABOUT ASRH

Lack of Awareness about AFHC

At the beginning of assessing parents' knowledge about SRH issues, this study tried to ascertain parents' awareness about the existence of AFHCs. Most parents said they were familiar with MCWCs or UHFWCs, but had no idea about the AFHC located in the MCWC or UHFWC. The

TABLE 10. PARENT CHARACTERISTICS

Characteristics	Number
FGDs	10
Urban area (MCWC)	5
Rural Area (UHFWC)	5
Participants	85
Female	39
Male	46
Education	
No education	25
Primary incomplete	20
Primary complete	15
Secondary incomplete	11
Secondary complete	10
Higher	4
Total children	321
Mean (per participant)	3.77
Number of children	
1-2	15
3-4	40
> 4	30

DGFP organized inception meetings with community people, adolescents, school teachers and representatives from local governments at every facility after introducing the AFHC. However, none of the parents who participated in the FGDs had participated in these inception meetings.

Main SRH Problems Affecting Adolescents

Parents were asked to identify the main SRH problems affecting their adolescents. Irregular menstrual cycles (long or short), vaginal discharge, menstrual cramps, urinary tract infections (UTI), malnutrition, headaches and lower abdominal pain were identified by the parents as the most important health problems facing adolescent girls. The most common problems affecting adolescent boys were wet dreams, UTIs, depression, anxiety, and weakness. In addition, some parents identified drug addiction as a serious health concern for adolescent boys.

Communication Gap Between Parents and Adolescent Children

FGD participants, both mothers and fathers, said that they feel uncomfortable discussing SRH issues with their adolescent children. Many mothers said they first discussed menstruation with their daughters only after they experienced menarche. Most mothers also reported they did not provide basic information about menstruation and associated changes to their daughters prior to menstruation. Fathers said their daughters talked to their mothers and other family members such as an elder sister, sister-in-law, grandmother, or maternal aunt if they faced any SRH problems. FGD participants also mentioned that neither their adolescent daughter nor son was likely to share their SRH problems with their father.

“Girls usually share their problems with their mother or sister in laws and boys share their problems with friends or grandfather. Neither girls nor boys share their problems with their fathers.”

-Male FGD participant, Thakurgaon

Some male and female FGD participants said that adolescent boys do not share any SRH problems with any family members, unless their health situation becomes serious. During the FGD, one mother said:

“I’ve a son and I can understand that he is going through wet dreams. I tried to speak with him about this but I felt shy to discuss this issue with him. It is really difficult for a mother to speak with her son about wet dream.”

-Female FGD participant, Moulvibazar

MISCONCEPTIONS AROUND ASRH

Suspicious of AFHCs as ‘Family planning clinics’

UHFWCs and MCWCs are known among communities as ‘family planning clinics’ and as health facilities where married women go for contraception, ANC, PNC and vaccination for their children. During the FGDs, several parents mentioned that if an unmarried girl visit these facilities for seeking services, people might relate her visit with an unwanted pregnancy.

“Many people in our community express suspicious attitude if they saw unmarried adolescent girls visiting the UHFWC. Not everyone has an open mind. Suppose I along with my daughter have come to visit FWC for a general illness but when people will learn about our visit, they will assume something bad about my daughter.”

-Female FGD participant, Cox’s Bazar

Many mothers also mentioned that menstrual problems and management is a women's matter which should be kept secret and private. As a result, many adolescent girls feel it is inappropriate to share their SRH problems with their parents or service providers.

"We (women) do not discuss menstrual related problems openly. We also guide our daughters not to disclose the issue in front of others. However, if our daughter face any serious problems in her reproductive organs, sometime we shared it with our husbands... It is a personal matter of women."

-Female FGD participant, Sirajganj

Problems Would be Solved After Marriage

FGD participants, both male and female, said that most women face some form of SRH problems during their adolescence. They also believe that these problems are part of the natural process of the passage to adulthood and would be resolved naturally after marriage when they enter regular conjugal life. Based on this perception, some parents feel that no services are necessary for those adolescents who suffer SRH problems.

"I suffered by irregular menstrual cycles during my adolescence which was very painful. It is not an unusual experience for women and generally it resolves after marriage."

-Female FGD participant, Sirajganj

"It is unnecessary to go the hospitals for irregular menstrual cycles or white discharge. Every women suffered from it when they were adolescent and it is resolved after marriage."

-Male FGD participant, Horipur, Thakurgaon

Perception about Health Facilities

As AFHCs are situated inside the existing health facilities, FGD participants were asked to share their own experiences receiving services from MCWCs and UHFWCs. FGD participants described negative experiences including lack of medicines, unfriendly behavior of service providers, lack of a waiting room, over-crowding and poor quality of services. Very few respondents mentioned the distribution of free contraceptive methods, door-to-door services by the health workers, lower costs than at private clinics, and free vaccinations as positive aspects of the MCWCs and UHFWCs. On the other hand, respondents shared a common view regarding the problem of the shortage of free medicines in MCWCs and UHFWCs. Unfriendly behavior by service providers was another important issue raised by many FGD participants. A female FGD participant shared her experience:

"I visited the facility several times when I was pregnant. I waited there for hours for taking the service. Service providers didn't behave well to me. Sometime I felt that if I had enough money, I would take service from private clinic."

-Female FGD participant, Moulvibazar

Another FGD participants shared her experiences about limited waiting spaces:

"There is not enough waiting space for the clients. Most of the client waited there by standing on feet. Representatives from different pharmaceutical companies were also gathered in the waiting rooms which made me uncomfortable."

-Female FGD participant, Patuakhali

RECOMMENDATIONS FROM PARENTS

At the end of the FGDs, participants were asked to share their views and suggestions for making the AFHC initiative more effective and functional. Participants identified the following areas for strengthening the AFHCs.

Separate Service Providers for Boys and Girls

Most of the participants shared a common view on the need to have female service providers for adolescent girls and male service providers for adolescent boys. Many parents mentioned that unmarried adolescent girls would usually feel shy disclosing their SRH problems with a male service provider.

Availability of Free Medicine

Almost every participant during the FGDs in all study locations emphasized the need to ensure a regular supply of free medicines for adolescent clients. One male FGD participants from Patuakhali said:

“Proper supply of medicine have to ensure. Government should also allocate extra medicine for adolescents. When people will come to know about the adequate medicine supply at the facility, they will be interested in visiting the corner with their adolescent children.”

-Male FGD participant, Patuakhali

Improve the Quality of Health Facilities and the Behavior of Service Providers

The importance of friendly behavior by service providers for ensuring quality service for adolescents was strongly emphasized by parents. A few parents also raised the need of advance training on adolescent health for service providers. One female FGD participant from Cox’s Bazar described the importance of friendly behavior as follows:

“Many of us are dissatisfied with the services of the government health facilities due to bad behavior of service providers. I personally do not expect that my daughter would receive unfriendly behavior from a service provider. If they behave badly with the adolescent girls, they wouldn’t want to visit that place for a second time and they would discourage other girls to visit the facility.”

-Female FGD participant, Cox’s Bazar

FGD participants suggested improving the poor infrastructure and the overall quality of services of MCWC and UHFWC.

“Government facility is for the poor people. But most of the facilities are itself so poor and backward. There is no MBBS doctor in our UHFWC. Besides, the facility building is also poor and damp. If you want to ensure good services for adolescents, you have to improve the overall condition of the facility.”

-Male FGD participant, Moulvibazar

Demand Generation for AFHCs

During the FGDs, parents were asked to share their views on the most effective ways of informing adolescents, parents, and community members about the AFHC initiative. Some parents emphasized involving school teachers to promote AFHCs. Other participants suggested organizing courtyard meetings in different areas with parents and community members to publicize the services and benefits of AFHC. According to one female participant from Cox’s Bazar:

“If you can organize courtyard meetings with the community people then people will understand the benefit of health corner for adolescents. Many parents do not know where to go for seeking health services for their adolescent children.”

-Female FGD participant, Cox’s Bazar

Another male participant from Sirajganj mentioned that uneducated parents are unable to read posters and banners, thus courtyard meetings or making public announcements through loudspeakers would be a more effective way of informing the community about AFHCs:

“Not everyone can read and will be able to read what is written in the poster or banner. There should be public meeting to let people know about AFHC. Or you can also miking [announce with a loudspeaker] the message through rickshaw.”

-Male FGD participant, Sirajganj

Chapter 5: Findings and Recommendations

This early assessment of selected AFHCs in MCWCs and UHFWCs provides important insights into what is working well and where are areas for improvements in the expansion of AFHCs moving forward. This chapter jointly summarizes the study findings from AFHC users and AFHC non-users, AFHC service providers and parents to provide an early assessment of this important GOB initiative to improve access to ASRH for unmarried and married adolescents in Bangladesh.

It is important to note that this study did not include boys or married adolescent girls in its data collection. Married adolescents have had access to FP and MCH services through the main MCWC and UHFWC facilities, and are therefore not the primary target population for AFHCs. During the planning and study design phase, the research team talked with service providers at AFHCs to better understand the gender and age distribution of adolescent clients who were using AFHCs. These discussions revealed that very few boys visited AFHCs for SRH problems during the program implementation period. Based on these discussions, the study team also learned that unmarried adolescent girls who visited the AFHCs for SRH problems were mostly older than 14 years of age. Thus, the study team decided to include unmarried girls between the ages of 15-19 years as the adolescent study population. We recognize that not having the voice of boys is an important omission and understanding how AFHCs can best meet their needs is important work in the future.

SUMMARY OF FINDINGS

Unmarried adolescent girls are using AFHCs. Although adolescence represents a generally healthy period of life, physical changes, sexual and reproductive health concerns (including worries about menstruation management, irregular periods, and white discharge), and mental health concerns (including feelings of shame) affected almost all adolescents interviewed for this study. There is clearly a need for AFHCs to address these concerns. It appears that AFHCs are reaching unmarried adolescent girls with a range of health services, both general and SRH-related, in established health facilities. This supports the global evidence that integrating adolescent friendly services into existing health delivery systems is more effective than establishing separate or stand-alone youth and/or adolescent centers or clinics. Based on review of the AFHC service registers in two MCWCs, it appears that users of the AFHCs are predominately unmarried adolescent girls, which is encouraging, as this is the target population for AFHCs.

The service statistics and in-depth interviews also suggest that AFHC users seek a broad range of services from AFHCs, beyond SRH services. It is also noteworthy that significantly few adolescent boys use the AFHCs and, based on the service statistics, appear to do so for general illness, rather than SRH services. An important limitation of this study is that adolescent boys were not included in data collection, so this analysis does not include in-depth information about why adolescent boys are not using the AFHCs. Further exploration is required to understand the reasons for boys' lower attendance.

AFHC users expressed satisfaction with AFHC service providers. The adolescent girls who received services from AFHCs were generally satisfied with how service providers treated them. This is especially noteworthy, given the social stigma associated with unmarried girls seeking services from facilities that are seen as 'family planning clinics' by parents and other community members. This suggests that the AFHS training that AFHC service providers undergo is having a positive impact on how service providers interact with adolescent girls.

Variation in the physical set-up of AFHCs impacts client access and privacy. Our study observed some variation in the physical set-up of AFHCs between MCWCs and UHFWCs. In the MCWCs, each AFHC was in a separate room or designated physical space. However, at the UHFWCs, only one out of five AFHCs had

a separate room. According to WHO guidelines, having a separate room is an important criterion for ensuring quality adolescent friendly health services. There is a need to ensure that physical space is allotted for AFHCs. This study revealed that some facilities found creative solutions, such as repurposing space that was not being used for its originally intended purpose.

Awareness of AFHCs is limited. Adolescents and parents had limited awareness of AFHCs. This may be because the AFHCs had only recently launched when this study was conducted. However, more publicity and generating awareness about the centers in the community is recommended. Adolescents' use of health services is highly influenced by the social values, attitudes, and taboos (perceived or real) of their parents and other gatekeepers, including service providers. Ensuring that these gatekeepers are also involved in awareness generation efforts will be critical for increasing the likelihood that adolescents will use AFHCs. For example, schools and teachers can a good source for sharing information about AFHCs and encouraging adolescents to visit.

Awareness-raising efforts provide a unique opportunity to 'rebrand' how adolescent friendly centers are viewed— as sources of prevention and counseling services, and not just as treatment centers. These centers have the potential to be seen and serve as important 'information hubs,' rather than considered as a place to go only if you have a problem. This shift of perspective may also reduce social stigma and barriers to adolescents accessing the centers.

AFHC users experienced challenges. While generally happy with the way AFHC service providers treated them, AFHC users described several limitations in accessing services at AFHCs. Many of these mirror larger health system challenges such as complaints about **shortages of medicine** and **lack of privacy** in the facility. Service providers also expressed frustration with intermittent supply of medicines, which mean they cannot always give free medicines to their adolescent clients. Another challenge that was raised by adolescents and parents is the need for a **separate waiting room** for AFHC users, to ensure their privacy. Some AFHC users also recommended separate waiting rooms for adolescent boys and girls to increase their comfort levels while waiting for services.

Concerns were raised by both clients and AFHC service providers regarding the **lack of BCC/educational materials** available in the AFHCs. There were strong recommendations for increased investment to ensure that a range of BCC materials are visible and available. These should include posters, booklets, and leaflets, and should address an expanded range of issues of concern to adolescents – e.g. mental health, substance abuse, early marriage prevention, and domestic violence.

An obvious issue that affects access to AFHCs are hours of operation. While some adolescents said the official service hours (8:30 am to 2:30 pm) did not pose an issue, others said that these timings were not convenient. Currently, the AFHC operates primarily during school hours, making it difficult for school-going adolescents to attend. Recommendations include offering evening service hours (e.g. 3:00 pm to 5:00 pm) once a week or service hours on Friday to see if that increases access for school-going adolescents.

AFHS-trained service providers described how taking on their role in the AFHC required them to be in **multiple places** throughout the day- outdoor service points to serve mothers and children and the AFHC to serve adolescents. The AFHS-trained providers talked about the additional demands created by their new responsibilities serving adolescents, while continuing to meet the needs of their regular clients (mothers and children). This increased workload and the need to choose when to be in the AFHC was stressful for some providers.

Most service providers in MCWCs **used outdoor service points** to serve adolescent clients rather than using the designated AFHC, due to their workload. Service providers should be supported and motivated to use the AFHCs so that adolescents can be confident that the service provider will be available when they visit. It is also

recommended that more service providers be trained in AFHS to increase availability of AFHS and prevent service provider burnout.

This early assessment of the AFHC initiative of the Government of Bangladesh is encouraging and offers specific recommendations for improving access, availability, and quality of adolescent friendly health services as AFHCs are expanded in the country.

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