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SITUATION ANALYSIS REPORT

Adolescents in Bangladesh:
A Situation Analysis of Programmatic Approaches to Sexual and Reproductive Health Education and Services

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List of Acronyms

ADP	Adolescent Development Programme
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
BCCP	Bangladesh Center for Communication Programs
BDHS	Bangladesh Demographic Health Survey
BRAC	Bangladesh Rural Advancement Committee
BRAC-IED	BRAC Institute of Educational Development
BRACU	BRAC University
CSE	Comprehensive Sexuality Education
DGFP	Directorate General of Family Planning
EKN	Embassy of the Kingdom of the Netherlands
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
GBV	Gender Based Violence
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
ICT	Information and Communications Technology
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
MCH	Maternal and Child Health
MCWC	Mother and Child Welfare Centers
MoHFW	Ministry of Health and Family Welfare
NCTB	National Curriculum and Textbook Board
NGO	Nongovernmental Organization
RCT	Randomized Controlled Trial
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UH&FWC	Union Health and Family Welfare Center
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Executive Summary

There are 29.5 million adolescents in Bangladesh, including 14.4 million girls and 15.1 million boys, together representing nearly one-fifth of the country's total population of 144 million. Although the health and well-being of this group is critical to the country's future, issues surrounding sexual and reproductive health (SRH) remain a cultural taboo, especially for adolescents and young unmarried people. Adolescents in Bangladesh too often enter their reproductive years poorly informed about SRH issues, without adequate access to SRH-related information or services.

Initiatives to address adolescent sexual and reproductive health (ASRH) in Bangladesh have been implemented by both the Government of Bangladesh (GOB) and nongovernmental organizations (NGOs), but these activities have often been fragmented and are not well documented or evaluated, making it difficult to know what worked well and what did not. With a large and growing adolescent population, it is critical to identify, invest in, and accelerate the expansion of proven approaches to ASRH programming. There is a need to understand which approaches can improve adolescents' knowledge of SRH issues and their access to and uptake of services, and to identify gaps in programming knowledge and practice. There is also a need to critically examine the evidence base for these programs to determine which interventions lack rigorous evidence of effectiveness and, more importantly, to identify and promote those that have been proven, through strong evidence, to effectively and efficiently provide SRH services that meet the needs of adolescents. Understanding what works and what does not for adolescent SRH interventions will help inform the scale-up of promising interventions, minimize duplicative efforts, and ensure efficient use of available resources.

This report presents findings from a comprehensive review and situation analysis of ASRH programming in Bangladesh, carried out by the Evidence Project/Population Council, with financial support from USAID/Bangladesh, as part of a larger research initiative on "Improved Adolescent Sexual and Reproductive Health (ASRH) Outcomes in Bangladesh." The objective of the review was to identify programmatic and evidence gaps, as well as best practices, and support the development of effective, inclusive, and sustainable ASRH programs that can operate at scale.

KEY FINDINGS

- **There is a lack of SRH programs that are exclusively focused on adolescents.** Of the 32 programs reviewed that had an SRH component, only 16 programs were exclusively targeted towards adolescents ages 10-19. The rest of the programs included adolescents not by design, but through their coverage of a wider age range of beneficiaries e.g. women of reproductive age (15-49), and did not include interventions tailored towards adolescents' specific needs. Younger adolescents were especially neglected: only two of the 32 programs reviewed had a tailored strategy for 10-14-year-olds. Since this is the stage when gender and sexual norms, values, and attitudes start forming, it is important to establish positive and responsible SRH attitudes and behaviors at this age.

- **ASRH programs are unevenly distributed across Bangladesh.** ASRH programs were highly concentrated in some districts, while other districts remain underserved. ASRH programs were also more highly concentrated in rural areas compared to urban areas, despite the fact that adolescents living in urban slums are a significant and vulnerable segment of the adolescent population.

- **Programs directed specifically to adolescents do not usually focus primarily on SRH, instead incorporating SRH as a secondary component, strategically bundled with other interventions.** Most often, programs that focused exclusively on adolescents often included SRH components as a secondary focus, incorporated into other, less controversial interventions (e.g. prevention of child mar-

riage) or into broader maternal and reproductive health services. This allows programs to address more sensitive and stigmatized topics, such as premarital sex, that would otherwise be considered taboo in Bangladesh's conservative, religious culture. Unfortunately, without a strong evaluation mechanism, it is difficult to determine the impact and effectiveness of specific program components.

- **ASRH programs focus predominantly on girls, with little specific attention to boys.** Although inequitable gender norms and attitudes in Bangladesh result in significantly greater vulnerability for girls (such as child marriage, early pregnancy, maternal death, and so forth), adolescent boys also face serious challenges in their transition to adulthood, particularly regarding SRH issues. Expanding the number of programs that address adolescent boys' SRH needs, alone or in conjunction with programming for girls, would contribute to improving national ASRH outcomes overall.

- **There is a critical gap in SRH information and services for unmarried adolescents, especially girls.** Married girls, due to the social acceptability of sexual union and child bearing inside marriage, are able to seek and receive a host of SRH, maternal health, and family planning services, irrespective of their age. However, programs and policies continue to restrict unmarried adolescents' access to SRH knowledge, information and services, which makes them vulnerable to health risks and discriminatory treatment. Efforts to mobilize communities to recognize these needs, to sensitize elders to fully appreciate the breadth of SRH issues beyond family planning and to accept the importance of SRH information and services for young girls and women, both married and unmarried, to lead healthy lives will play a major role in making advances on this issue.

- **Health facilities are seen exclusively as "family planning clinics."** Adolescents, and communities in general, view GOB and NGO health facilities as "family planning clinics," which creates a major barrier for unmarried adolescents to visit these centers. In addition, health services are often clinically oriented, and opportunities for preventive interventions are frequently overlooked. There are however increasing efforts, including by the GOB, to make SRH information and selected services available to adolescents, including for unmarried girls, e.g. the establishment of Adolescent Friendly Health Corners in select GOB facilities. Additional efforts are needed to begin to change the perception among communities and adolescents themselves that health facilities are exclusively for family planning services for married women.

- **Traditional, awareness raising approaches remain the most common, but without a strong base of evaluation and evidence.** Community-based or school-based awareness raising activities, peer education, and youth centers remain the most frequently used in ASRH programming. However, there has been very limited evaluation of their impact on SRH behavioral change among adolescents. Moreover, these approaches do not generally have an SRH services component or referrals to SRH services, which may further limit their impact.

- **School-based interventions are increasingly popular as a strategy for reaching adolescents, but face serious implementation challenges.** School based interventions are increasingly considered as a viable avenue to reach adolescents in their early years with SRH information, but implementation of these interventions is hindered by stigma and the reluctance of teachers to discuss SRH issues. Also, these efforts do not usually include a mechanism to meet adolescents' needs for psychosocial counseling and SRH services.

- **More emphasis is needed on rigorous evaluation and generation of evidence of what works.** Of the 32 reviewed programs, only three employed rigorous evaluation methodologies to determine the impact and effectiveness of programs. Many programs involved short-term evaluations, with limited evidence of long-term behavioral impact, and most of the studies did not highlight aspects of the

interventions that did not work. Program documentation, if it exists at all, is also limited. This makes it difficult to measure a program's impact, and results in missed opportunities for future programs to learn from past experiences and avoid implementing approaches that have proven to be ineffective.

- **Innovative, age-appropriate interventions are emerging, but must be tested.** Non-traditional, age-appropriate interventions, such as sports-based interventions, the use of information and communications technology (ICT), and game-based or interactive interventions are starting to appear in Bangladesh. These approaches may be effective ways of reaching adolescents, particularly young adolescents ages 10-14. However, these approaches must be tested for impact and potential scale up upon completion.

- **There is a lack of coordination between stakeholders and collaboration with the government.** More coordination and collaboration is needed among partners in the ASRH field, including the government. Creating opportunities through existing structures and platforms for increased collaboration between the various implementing NGOs and stakeholders working in ASRH and the Government of Bangladesh is essential for the advancement and sustainability of ASRH programs.

Introduction

Adolescence, defined as the period between 10–19 years of age, is characterized by rapid social, physical, and emotional changes (Dube and Sharma 2012). For too many young people around the world, the onset of adolescence brings not only changes to their bodies but new vulnerabilities to human rights abuses, particularly in the arenas of sexuality, marriage and childbearing. According to the Guttmacher Institute, most adolescents become sexually active by their late teens: 40% of women in Latin America, 60% of women in sub-Saharan Africa and 52% of women in America had sex by the age of 18. Pregnancy and childbirth are among the main contributors to disease and disability among adolescents: early childbearing is linked with higher maternal mortality and morbidity rates and increased risk of induced, mostly illegal and unsafe abortions (Blanc, Winfrey, and Ross 2013; Ganchimeg et al. 2013; World Health Organization 2014). Millions of girls are coerced into unwanted sex or marriage, putting them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV, and dangerous childbirth (Shah and Åhman 2012). Lack of proper sex education leaves adolescents ill-informed about sexuality and unprepared to protect themselves from possible negative outcomes such as STIs (Glasier et al. 2006; Haberland and Rogow 2015). Young people specifically are disproportionately affected by HIV: an estimated one million young people, ages 15–24, are infected with HIV every year, representing 41% of all new infections among those aged 15 years and older (UNAIDS 2010).

Many adolescents, including those who are sexually active, have difficulty finding information and knowledge about adolescent sexual and reproductive health (ASRH). Moreover, those able to find accurate information about their sexual health and rights may be unable to access the services needed to act on that knowledge and protect their health (UNESCO 2009). This may be due to an absence of appropriate service locations or to adolescents' lack of financial and social autonomy, which limits their ability to seek ASRH knowledge and services. Meeting the sexual and reproductive health (SRH) needs of adolescents requires ensuring that adolescents are aware of and able to access SRH information and services voluntarily, comfortably, confidentially, and without fear of discrimination.

Countries around the world face similar issues related to ASRH, though different cultural contexts have a significant impact on how those issues are experienced and addressed, including specific barriers adolescents encounter when trying to access SRH information and services.

CONTEXT OF BANGLADESH AND ASRH

There are 29.5 million adolescents in Bangladesh, including 14.4 million girls and 15.1 million boys, together representing nearly one-fifth of the country's total population of 144 million (BBS, Population Census 2011). Despite the size of this subpopulation and their unique SRH needs, the scope of ASRH programming in Bangladesh has remained limited (see **Box 1**). Adolescents in Bangladesh face a number of issues, including high rates of early marriage, high fertility rates, limited negotiation skills, and insufficient awareness of and information about reproductive health (Barkat and Majid 2003).

Adolescents in Bangladesh often enter their reproductive years poorly informed about protection from pregnancy and infection and their reproductive choices (IPPF 2009). Girls and boys have very different experiences in adolescence, particularly related to expectations around marriage and childbearing: social and cultural factors such as social insecurity (fears of being harassed or labeled as "bad"), social norms regarding age and girls' marriageability, and dowries create pressure on girls to marry and bear children at a young age (Amin, Mahmud, and Huq 2002; Amin, Selim, and Waiz 2006). The median age of marriage for women is 15.5, compared to 26 for men and – more seriously – the rate of child marriage in Bangladesh is one of the highest

BOX 1

WHAT DO WE MEAN BY 'ASRH' PROGRAMS?

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

in the world, with two out of every three girls married before the age of 18, and one third before age 15 (NIPORT, Mitra and Associates, and ICF International 2015). Adolescent girls enter married life without proper knowledge of contraception and with limited ability to exercise their reproductive rights, including decisions related to family planning, childbearing and maternal and child health services, and usually begin childbearing soon after marriage (Khan, Townsend, and D'Costa 2002). One recent study conducted in southern Bangladesh described how child marriage leads to early and mistimed pregnancies, in part due to young girls' lack of power and agency (Ainul and Amin 2015). Another recent survey, conducted in the Southwestern region of Bangladesh, found that 50 percent of married adolescents (ages 12-19) had been pregnant before, and that 22 percent gave birth by age 15 (Amin et al. 2014).

These practices contribute to making adolescent fertility in Bangladesh among the highest in the world. According to the latest Bangladesh Demographic Health Survey (BDHS), adolescents ages 15-19 contribute up to one-fourth of total fertility (NIPORT, Mitra and Associates, and ICF International 2015). While use of modern contraception by women of reproductive age (15-49 years old) is 52 percent overall, it is only 42 percent among 15-19 year old adolescents (NIPORT, Mitra and Associates, and ICF International 2015). Rates of contraceptive use are even lower among those who have not yet had children: Amin and Bajracharya (2011) found that just 20 percent of married adolescents without children were using contraception, compared to 42 percent among all adolescents.

In spite of these figures, SRH is still a cultural taboo in Bangladesh, especially for adolescents and young people, and particularly outside marriage. Parents do not feel comfortable discussing SRH issues with their adolescent children and schools provide very limited or no information on SRH. Adolescents often face difficulty getting information and guidance regarding these issues, and their access to SRH-related services is even more limited (Nahar et al. 1999). Because they lack access to essential information, very few adolescents in Bangladesh are aware about their sexual and reproductive rights.

A recent qualitative needs assessment undertaken in Dhaka (BIED, BRACU 2012) found that adolescent girls and boys were insufficiently informed or misinformed about sexual and reproductive health and rights (SRHR) because of lack of information from parents and school teachers. Both boys and girls displayed some limited knowledge of HIV/AIDS, but no awareness of other STIs. Similarly, a recent study in the Dhaka slums (Rahman, Hossain, and Amin 2012) showed, among girls and women ages 15-19, inadequate knowledge about SRHR issues, including sexual rights, reproductive health and rights, period of pregnancy risk during the menstrual cycle, adverse effects of teenage pregnancies, emergency contraception, and service points for SRH services.

Donors and policy makers are increasingly advocating for comprehensive sexuality education (CSE) to improve adolescent health and wellbeing. CSE programs provide age-appropriate, scientifically accurate, and culturally-relevant information on SRH, including SRH rights, services, and healthy behaviors (UNESCO

2009). CSE in and out of schools has been shown, in a variety of cultural and socio-economic backgrounds, to be effective in delaying initiation of sexual activity, reducing unintended pregnancy, and increasing condom and contraceptive use (Alford S et al. 2003; Haberland and Rogow 2015; Patton et al. 2016).

In addition to CSE, adolescents need increased access to SRH and other health information and services in order to delay their first birth and reduce the rate of adolescent pregnancy overall. Confidentiality, respectful treatment, integrated services, culturally appropriate care, free or low cost services, and easy access are all widely recognized as the cornerstones of appropriate services for adolescents and young adults (World Health Organization 2012). Globally, providing adolescent friendly services to ensure SRHR for adolescents has been complicated by service providers' biases and by stigma, among other barriers (African Youth Alliance/Pathfinder 2013; Jejeebhoy et al. 2014).

INITIATIVES OF THE GOVERNMENT OF BANGLADESH IN ASRH

The Government of Bangladesh (GOB) has articulated its commitment to improving access to ASRH services through numerous policy and program documents, including the Population Policy (2005), the Adolescent Reproductive Health Strategy (2006), and the National Plan of Action for Adolescent Sexual and Reproductive Health (2013). These documents provide the basis for engaging with the government, nongovernmental organizations (NGOs), and private sector partners. While there are cultural barriers to providing contraception to unmarried adolescents, as well as reservations about offering sex education to very young adolescents, the official policy in Bangladesh recognizes the strategic importance of investing in adolescents. Ministry of Health and Family Welfare (MoHFW) is also committed to increasing adolescents' access to SRH information and services through adolescent friendly health services (AFHS). As part of that commitment, MoHFW recently introduced adolescent friendly health corners (AFHCs) in existing health facilities (specifically, Union Health and Family Welfare Centers (UH&FWC) and Mother and Child Welfare Centers (MCWC)).

NGOs AND DEVELOPMENT PARTNERS IN ASRH

In addition to GOB, NGOs and development partners, including UN agencies and many bilateral and multilateral donors, are active in the ASRH field in Bangladesh. NGOs, with support from a number of international donors, have been lobbying for the inclusion of ASRH in the national agenda and are implementing programs and interventions that address ASRH issues, both directly and indirectly.

NGOs and development partners have different priority areas and have responded to the need for ASRH in multi-dimensional ways. Most NGOs and partners work in coordination with GOB, and new networks and forums are being created to share knowledge, experience, and research, and to promote combined interventions. The majority of ASRH interventions involve education and health services, with NGOs and donors taking increasingly innovative approaches and becoming more inclusive in their coverage of target groups. There is also a growing effort to reach out to rural areas alongside the urbanized and rapidly growing city centers, and recent initiatives have sought to involve the private sector in ASRH programs.

Methods

The Evidence Project/Population Council team conducted a situation analysis of ASRH programs and interventions implemented in Bangladesh in the last decade. The review was based on existing program documentation, including baseline reports, project briefs, project documentation of interventions, and final evaluation reports. Activities undertaken as part of this review included: identification of SRH programs in Bangladesh with a focus on adolescents, collection of relevant programmatic information, engagement of key stakeholders, analysis of selected programs, field visits to current ASRH programs, and communication (including interviews) with ASRH program managers.

Identification and collection of relevant programmatic information: The review was primarily based on secondary literature collected through an online search of electronic databases, including Google, Google Scholar, and PubMed. Search terms used included "adolescent development projects," "adolescent sexual and reproductive health rights projects in Bangladesh," "adolescent improvement projects," "adolescent health services," and "peer education project." The search also included the names of the international and national NGOs engaged in ASRH-related projects in Bangladesh.

The search was extended to the websites of government ministries, NGOs, and research organizations engaged in ASRH-related issues. These organizations include the Bangladesh Rural Advancement Committee (BRAC), CARE, Save the Children, Plan International, Bangladesh, icddr,b, Family Planning Association of Bangladesh (FPAB), UNICEF, UNFPA and Marie Stopes, among others. Information was collected through visits to organizations' offices, emails, and telephone conversations with program managers. Program documentation reviewed included final evaluation reports, baseline reports, project briefs, and project documentation of interventions.

Engagement of key stakeholders: To determine the inclusion criteria for programs in the review, a series of meetings were held with key governmental, non-governmental, donor and development partner stakeholders. These included BRAC, BRAC Institute of Educational Development (BIED), BRAC School of Public Health, UNFPA, USAID, UNICEF, FPAB, Save the Children, CARE, Plan International, and icddr,b. Inclusion and exclusion criteria to guide program review and mapping were finalized at an inception meeting with a core group of stakeholder representatives.

Program site visits: The Evidence Project/Population Council study team communicated with managers of ASRH programs and visited their program sites to understand the intervention modality and the challenges and strengths of each program. The study team visited a subset of ASRH programs, selected based on geographic diversity and mode of intervention, on multiple occasions to gather in-depth information.

Inclusion criteria: Based on discussions at the key stakeholder meetings, programs were included in the review if they met the following criteria:

1. They were implemented between 2005 and 2015. Going beyond ten years was deemed to be counterproductive, given the societal changes that have occurred in Bangladesh over the past decade.
2. They included young people ages 10-24 as target beneficiaries. Adolescents 10-19 years old were the primary group of interest for this review, with additional emphasis on young adolescents (10-14 years old) to improve coverage of unmarried adolescent females, who are often excluded from ASRH projects. Projects focusing on adolescents 10-19 years old were included in this review, with a particular emphasis on those working with young adolescents (10-14 year olds) Since many programs work with broad age ranges, programs or interventions addressing wider age groups that included adolescents

(e.g. 10-24 year olds and 15-49 year olds) were also reviewed.

3. They included some programmatic focus on ASRH. Programs or interventions were included in the review if they focused on any element of ASRH (e.g. reproductive health, family planning, gender-based violence (GBV), child marriage, etc.), although ASRH did not have to be the specific focus. Programs that did not address any aspect of ASRH were excluded. For instance, if a project aimed to delay marriage through a life skills intervention, but ASRH was not explicitly an outcome of interest, the program was included in the review, since child marriage is considered an ASRH issue.
4. They had some documentation of the mechanism of the intervention and monitoring and evaluation processes. The review looked at evaluation mechanisms, but given the negligible number of programs with rigorous evaluation, the lack of such evaluation was not considered an exclusion criteria.

Based on these criteria, **32 programs and interventions were identified** and included in this review. See **Table 1** for the distribution of programs by age and gender and **Appendix 1** for a complete listing of programs.

Data and information on these programs were systematically analyzed by a team of Evidence Project/Population Council researchers, who examined and categorized the programs by geographic focus, program themes, and programmatic approaches. Programmatic challenges and successes were also identified and summarized. A core group of external stakeholders with an interest in ASRH in Bangladesh further strengthened the analysis through a series of consultations.

TABLE 1. DISTRIBUTION OF PROGRAMS BY AGE AND GENDER

AGE GROUP	GIRLS ONLY	BOYS ONLY	COMBINED	TOTAL PROGRAMS
10 – 19	7	-	9	16
10 – 24	-	-	9	9
MIXED, BETWEEN AGE 15 AND 49	3	-	3	6
15 – 19, MARRIED	1	-	-	1
TOTAL	11	-	21	32

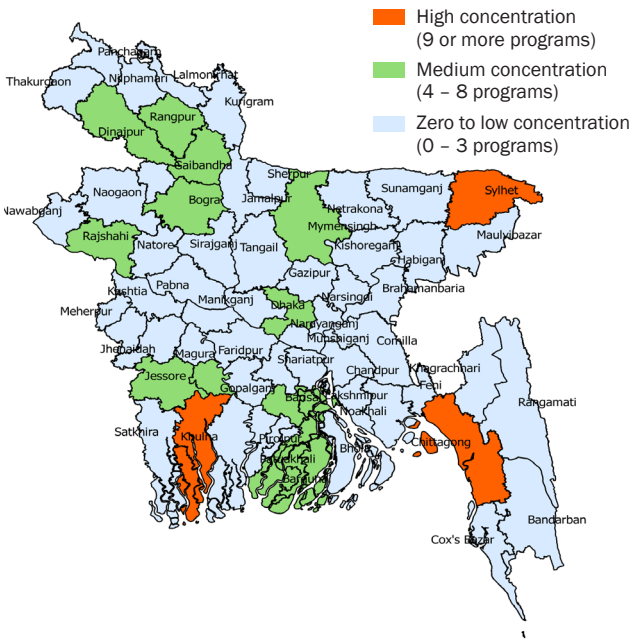
Results

A. GEOGRAPHIC COVERAGE AND PROGRAM DURATION

I. Geographic Coverage

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

MAP 1. DISTRICTS BY LEVEL OF PROGRAM COVERAGE

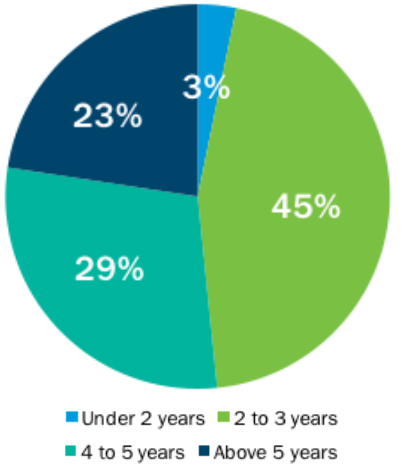


The low concentration of programming across much of Bangladesh suggests there may be a need to expand ASRH programs to underserved areas, using evidence to determine priority areas for programming. Careful analyses of national indicators and documentation of ASRH needs will help focus future investments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

II. Program Duration

The review found significant variation in program duration (**Figure 1**). Over half of the programs were implemented for more than three years (29 percent for 4-5 years and 23 percent for more than 5 years), while slightly less than half (45 percent) were implemented for two or three years. Although optimal program duration has not been determined, the finding of longer interventions and programs is encouraging, as longer programs enable interventions to reach optimal effectiveness and generate useful lessons for evidence-based programming and planning. Among programs that lasted more than five years, a few select programs have been run continuously for over two decades, although the ASRH components of some were phased in more recently as the SRH needs of adolescents have gained greater attention.

FIGURE 1. DISTRIBUTION OF PROGRAMS BY DURATION



B. THEMATIC FOCUS AREA

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

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

The analysis identified the a few key trends in the thematic focus areas of reviewed projects.

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

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

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

Due to institutional, policy, and social norm-related barriers, programs that focused exclusively on adolescents did not typically have a significant focus on SRH. When programming for adolescents included SRH-related components, they were typically a secondary focus, incorporated into other, less controversial gender-related interventions such as prevention of child marriage and GBV or into broader maternal and reproductive health services, including family planning (FP) and maternal health. Only nine programs of the 32 reviewed had SRH as a primary focus and were exclusively focused on the 10-19-year-old age group. The bundling of SRH interventions with other, more acceptable interventions is strategic, however, allowing programs to address more sensitive and stigmatized topics - such as premarital sex and teenage pregnancy outside of marriage - that would otherwise be considered taboo in Bangladesh's conservative, religious culture. Additionally, incorporating SRH interventions into broader programs expands opportunities to provide services to unmarried adolescents, many of whom would otherwise have no access to healthcare services. Unfortunately, for bundled interventions without a strong evaluation mechanism, it is difficult to determine the impact and effectiveness of specific program components.

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

The adolescent programs reviewed were disproportionately focused on girls, with very little programming for boys. Among the 32 programs reviewed, 11 programs focused exclusively on girls and the remaining 21 targeted both genders. None of the programs reviewed had an exclusive focus on adolescent boys. The focus on girls is understandable, given that inequitable gender norms and attitudes in Bangladesh result in significantly greater vulnerability for girls (such as child marriage, early pregnancy, maternal death, and so forth). However, adolescent boys also face serious challenges in their transition to adulthood, particularly regarding SRH issues. There has been a paradigm shift in recent years to recognize masculinity as a crucial aspect of gender and include boys in efforts to transform gender norms. Within ASRH programming, more spaces are being created for boys to express themselves, in order to improve programmers' understanding of the problems, issues, and dilemmas they face. This has the potential to contribute to more effective and long term resolutions for deep-rooted issues, especially normative problems like GBV or child marriage. One innovative ASRH pro-

gram that works with adolescent males is Generation Breakthrough. This program addresses gender equity and violence prevention through sports based activities with adolescents, with an emphasis on reaching boys. Expanding the number of programs that address adolescent boys' SRH needs, alone or in conjunction with programming for girls, would contribute to improving national ASRH outcomes overall.

Younger adolescents and unmarried girls are also neglected in programming.

Unmarried girls and younger adolescents face even more stringent barriers in addressing their SRH needs than their married and older peers. Married girls, due to the social acceptability of sexual union and child bearing inside marriage, are able to seek and receive a host of SRH, maternal health, and family planning services, irrespective of their age. However, their unmarried counterparts are typically barred from receiving the same services, as a matter of policy and practice.

ASRH information and - especially - services have been limited almost exclusively to married adolescents in Bangladesh because, despite encompassing a broad range of SRH issues important to young girls and boys, ASRH is seen as synonymous with family planning, which under the conservative Bangladeshi context is only permissible for married women and couples. As child marriage continues to be a significant issue in Bangladesh, there are millions of adolescents who are already married, and there are policies, interventions and programs that address the SRH needs of married adolescent girls. Programs and policies continue, however, to restrict unmarried adolescents' access to SRH knowledge, information and services. There have been some efforts, through approaches such as awareness-raising and sensitization, anonymous question-and-answer sessions, tele-counseling, group discussion, peer education, and primary and secondary school teachers training, that have seen some success reaching unmarried adolescents, but the need is significantly unmet. The systematic exclusion of unmarried adolescents, especially unmarried girls, from SRH services makes them vulnerable to health risks and discriminatory treatment. Efforts to mobilize communities to recognize these needs, to sensitize elders to fully appreciate the breadth of SRH issues beyond family planning and to accept the importance of SRH information and services for young girls and women, both married and unmarried, to lead healthy lives will play a major role in making advances on this issue.

The standard SRH packages for unmarried and married adolescents offered at government health facilities are shown in **Table 2** below.

TABLE 2. STANDARD SRH INFORMATION AND SERVICES PACKAGE FOR ADOLESCENTS AT GOVERNMENT HEALTH FACILITIES

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

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

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

It is crucial to address early adolescents in policies and programs, since this is the age when gender and sexual norms, values, and attitudes start forming, and many adolescents become sexually active during this period or soon after. Establishing positive and responsible SRH attitudes and behaviors at this age will have lifelong positive impacts on SRH as well as gender roles and practices.

Programs frequently bundled SRH interventions for adolescents with other, more socially acceptable interventions to ensure the provision of services to younger adolescents and unmarried adolescents, many of whom otherwise have no access to SRH services.

Sexuality, sexual identity, and recognition of diverse identities are missing in the landscape of ASRH programs.

Most SRH programs focus on reproductive health issues (e.g. family planning, maternal care, and so forth) but neglect sexual health. In particular, sexuality, sexual identity, and sexual rights are seen as taboo and often not addressed openly, and the needs of marginalized adolescents (marginalized because of poverty, ethnicity, gender or sexual identity, among other reasons) are largely ignored. Among other concerns, an explicit focus on HIV services for adolescents is lacking. One program, Link Up, does specifically target adolescent youth, both males and females, ages 10-19, with a direct focus on developing and strengthening HIV and SRH service integration. This program is novel in its provision of peer-based counseling and community-based HIV and SRH services, but highlights the lack of existing ASRH programs and interventions addressing HIV.

C. ASRH PROGRAMMING APPROACHES

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

I. Awareness Raising Approach

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

Community-based model

Community-based models for awareness raising have been a mainstay in broader development programming for decades. These models were used in some of the earliest SRH programs in Bangladesh (such as AVIZAN and APON) and continue to be a common approach. In recent years, community-based models have been extensively employed in programs targeting adolescents, including in ASRH programming. Nearly all the programs considered in this review used some form of a community-based model to raise awareness about SRH issues among adolescents, often in combination with school-based or health facility-based models (see **Box 2**), or with media campaigns.

Community-based models have been popular in Bangladesh, as elsewhere around the world, because of their expansive reach. In community-based models, adolescents receive SRH information and in some instances

BOX 2

SCHOOL OUTREACH VS. SCHOOL-BASED MODEL: AN IMPORTANT DISTINCTION

Some organizations that have been implementing ASRH programs through community-based models have recently started to incorporate a school outreach component in their programs. Unfortunately, these school outreach components are limited in scope, often with inadequate programming (i.e. too few sessions) and with uneven planning and implementation. In many cases, school outreach components involved only a single session at the school. Occasionally service providers from the implementing NGO will organize a one-day satellite camp on the school premise and offer counseling, blood pressure, vitamin, and tetanus vaccine services to generate interest among adolescents. Overall, school outreach models as they have been implemented thus far involve too limited contact with adolescents to achieve significant impact on ASRH outcomes.

services, alongside other social services, combined with age-appropriate recreational activities. Community-based awareness raising programs and sessions for adolescents are typically organized in community common spaces such as village squares, courtyards or playgrounds, or through "safe spaces" programs that are implemented through adolescent clubs, youth centers or "fun" centers.

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

Peer educator model

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

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

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

CASE STUDY 1

Text box and photo: Shishuder Jonno peer education program

Shishuder Jonno

Duration
2008 to date

Implementing Organization
Save the Children

Funder
Save the Children

Save the Children's "Shishuder Jonno" program provides SRHR education and livelihood training to adolescents (10-19 year olds) in the Meherpur District. The project has established 77 adolescent clubs where adolescents can spend time with their peers and attend education sessions run by peer educators. These sessions cover a variety of adolescent SRHR-related information, including menstrual hygiene, family planning, and child marriage. The in-school component of the project additionally provides menstrual hygiene management kits and vision tests.

In spite of the popularity of this model, there is limited evidence in the global literature for the effectiveness of peer education (Harden, Oakley and Oliver 2001; Medley, Kennedy, O'Reilly and Sweat 2009; Kim and Free, 2008; Tolli 2012; Walker and Alvis 1999). Programs that employ this model should examine the evidence base, carefully consider the utility of this approach, and apply rigorous monitoring and evaluation standards to peer education components to ensure the effectiveness of these programs in delivering positive impacts for adolescents.

School-based model

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

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

As school-based models for awareness raising are new in the field of ASRH programs in Bangladesh (see **Box 3** for a comparison of school-based and community-based approaches), evidence about the impact of this model on ASRH outcomes is still limited. However, our review revealed that there may be some significant challenges to effectively implementing school-based models for ASRH in Bangladesh. This includes the complexity of coordinating with school management committees and the Ministry of Education and the barriers in obtaining approval for ASRH awareness raising activities and curricula, as these topics remain sensitive in Bangladesh. School-based programs are also typically unable to include service delivery or referral to health services, which limits their impact on ASRH outcomes.

BOX 3

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

One of the programs reviewed for this study (ARSHI-ITSPLEY) shed some interesting light on the relative advantages and disadvantages of school-based models and community-based models. The program's final evaluation compared recruitment, acceptance, and participation between the school-based and community-based models. The comparison showed that recruitment and participation was better in the school-based models, compared to community-based models. However, community-based models generated greater enthusiasm and openness among participants, compared with adolescents who were reached by a school-based model. Since teachers may not feel prepared or comfortable addressing culturally-sensitive ASRH issues, community-based models may also be a more feasible channel for sharing information and discussing those topics than schools. Our review suggests that although most programs are set either in schools or in communities, there is an increasing use of integrated approaches that work both in schools and communities, taking advantage of the strengths of both models (for example, UBR, GOAL, and P SAFE adopt both school and community based models).

Most significantly, teachers may not be prepared to effectively implement school-based ASRH programming. In 2012, the government's National Curriculum and Textbook Board (NCTB) introduced content on Adolescence and Reproductive Health for the curricula standards for classes 6 to 10 (see **Table 3**). Although not covered in great detail, the inclusion of key ASRH topics could have been an opening for teachers, parents and adolescents to talk about this issue and used to anchor many non-government initiatives and interventions. No specific research has been done on the implementation or effectiveness of the national SRH curriculum, but reports indicate that, unfortunately, this curriculum is not being implemented due to teachers' reluctance to teach these topics in the classroom. A repeated theme in informal communication with teachers and program managers is that students are asked to read these chapters on their own, as teachers are not comfortable discussing topics that are perceived as sensitive. For a school curriculum intervention to be effective, more sensitization, training, and support for teachers will be required.

TABLE 3. SRH TOPICS INTRODUCED BY NATIONAL CURRICULUM AND TEXTBOOK BOARD

Class 6	Class 7	Class 8	Class 9 - 10
Physical, psychological changes during puberty	Physical, psychological and sexual abuse	AIDS Awareness: Symptoms and prevention	Physical, behavioral and psychological changes
Role of parents during puberty	Physical and psychological wellbeing – ways to protect and reaching out for help	Early pregnancy: Risks and consequences	Coping with mental pressure during puberty
Dos and don'ts during menstruation	Addiction: Consequences and prevention	Reproductive health	Reproductive disease (Cancer, HIV)
Nutritious and balanced diet	Early marriages and dowry		Preventing early pregnancy
Peer pressure in adolescents – smoking and alcohol			Safe motherhood

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

Community Mobilization

The community mobilization model has also been extensively used in ASRH programming, typically in conjunction with other awareness raising models, including the three described above. Elements of community mobilization were found in all 32 programs reviewed.

In Bangladesh's conservative social context, the support of gatekeepers - parents, community leaders, religious teachers and opinion leaders – is critical for the success of ASRH programs. The community mobilization model targets these gatekeepers and decision-makers, instead of the adolescents themselves, sensitizes them on SRH issues and their importance for young people in the community, and works to gain their acceptance to implement ASRH programming.

In Bangladesh...the support of gatekeepers - parents, community leaders, religious teachers and opinion leaders – is critical for the success of ASRH programs.

One limitation of community mobilization models is that adolescents and youth continue to be largely excluded from these community dialogue processes and are not engaged in community decision-making. For communi-

ty mobilization to be truly successful, youth and adolescent voices must be heard and appreciated by these influential gatekeepers and leaders. There has been a recent shift from treating adolescents as passive and powerless to recognizing that they can be effective agents of change, and an increasing number of programs (UBR, SSCOPE) are designed to include active participation by adolescents and youth in the community mobilization process.

II. Service Delivery Approach

Service delivery was the second major approach used in ASRH programming in Bangladesh, used by 19 of the 32 programs. Of the 19 programs that had a service delivery component, most included both clinical services (in-person visits with health care providers, testing services, prescriptions, provision of contraceptives, and so on) and non-clinical services (SRH information and counseling, but no medical intervention). Clinical services are often implemented in conjunction with programs that combine SRH and FP or maternal health services, including adolescents only as a subset of a broader and older group of target beneficiaries (e.g. women of reproductive age). Non-clinical services are more often targeted specifically to unmarried adolescents and are delivered either in person at adolescent friendly centers or via tele-counseling (through a toll-free hotline).

Although a number of programs are implementing a service delivery approach, there are significant barriers to SRH service delivery for adolescents in Bangladesh. This review revealed that even when adolescents have opportunities to access clinical services at health facilities, a large segment (particularly those who are unmarried) are not inclined to do so. Generally, non-clinical services were far more likely to be used by unmarried adolescents than clinical services.

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

Some programs have introduced initiatives to address some of these challenges in their service delivery interventions. For clinical service delivery, the government has introduced Adolescent Friendly Health Centers (AFHC) to improve access to both high quality SRH services and information tailored to the specific needs of adolescents (see **Box 4**). For non-clinical services, small scale but earnest efforts to provide SRH information and counseling to adolescents through youth centers by posting counselors at the center, or through safe space programs that refer to facilities that can deliver clinical services, are increasingly being used. However, the reach of these initiatives, as well as the quality of programs and capacity of counselors and staff trained to provide these non-clinical services, have remained limited.

Irrespective of whether services were clinical or non-clinical, the review revealed a significant lack of approaches that address the connections between SRH, adolescent mental health, and substance abuse or that use psychosocial counseling approaches. Similarly, the policy environment also remains strongly in favor of the delivery of clinical SRH services only to married adolescents, with limited likelihood for change.

BOX 4

ADOLESCENT FRIENDLY HEALTH CENTERS (AFHCs)

AFHCs are being created at ten government facilities (five Mother and Child Welfare Centers and five Union Health and Family Welfare Centers) in five districts (Sirajganj, Cox's Bazar, Patuakhali, Moulovibazar and Thakurgaon) with support from UNFPA, and the government plans to expand to other districts. Other partners (including UNICEF, Plan, and Save the Children) are beginning to collaborate with the government to establish and help operate AFHCs in other areas. The AFHCs are intended to meet the specific SRH needs of adolescents, with a focus on improving access to SRH information and counseling and selected clinical services (treatment for reproductive tract infections, menstrual problems and management, treatment of anemia, general health treatment, and tetanus vaccine). Although there is some evidence in the global literature that adolescent health centers have not been effective, particularly due to implementation challenges, this approach may nevertheless be the optimal strategy in the particular context of Bangladesh where there are institutional and cultural challenges to reaching adolescents with critical SRH services. These centers represent an important step in government-endorsed provision of SRH services for young people and recognition of the importance of these services for their health. Moreover, rather than being standalone facilities, in the GOB initiative, AFHCs are built as parts of existing facilities where community members (both women and men) already seek healthcare, which may reduce the stigma and other barriers adolescents – especially unmarried girls – face when seeking SRH information and services. The government's investment in AFHCs signifies a recognition that in the Bangladeshi context, AFHCs are uniquely positioned to fill a critical gap by delivering information and services to adolescents, for whom SRH information and services are not readily available. To inform this investment and guide future expansion of AFHCs, the Evidence Project/Population Council is assessing implementation challenges and successes of the AFHC initiative.

CASE STUDY 2

Tarar Mela

Duration
2011 – 2015

Implementing Organization
FPAB

Funder
EKN

The Tarar Mela initiative, led by FPAB under the United for Body Rights (UBR) Alliance, offers adolescents a range of health services, with an emphasis on SRH, including counseling, supplies, and referrals for medical services. The program, which is open to all adolescents in the community, offers both face-to-face counseling and tele-counseling on a variety of health issues, including SRH. Tarar Mela youth centers keep separate log books and have separate counseling rooms for male and female members, to maintain privacy and confidentiality. Sanitary napkins and contraceptives are offered at a low cost, and – for young people who may still be concerned about confidentiality - toilets at the center are stocked with a limited number of supplies (napkins, condoms, and oral pills). Counselors at the youth centers can refer members to the adjacent FPAB clinic for medical services, if needed. In addition to the medical and counseling services, Tarar Mela members also have access to a library, computer training, English lessons, talent competitions, and singing and dancing events. Finally, Tarar Mela offers an online CSE program titled 'Me & My World,' which combines IT skills with educational entertainment. These efforts have resulted in an increasing number of young people visiting Tarar Mela centers.

Innovative and Emerging Approaches in ASRH Programs in Bangladesh

A handful of programs have begun to implement new, innovative approaches to improving ASRH in Bangladesh. This includes using information and communications technology (ICT), sports-based programming, incorporation of mental health counseling, and new approaches to making services youth friendly. Although these approaches hold promise, additional research is needed to strengthen the evidence base for their impact and effectiveness.

This section presents detailed case studies of programs implementing these innovative approaches.

CASE STUDY 3

GOAL Photo Courtesy: Sigma Ainul, Population Council

Sports as an ASRH Intervention Strategy

Sports programs create an opportunity to reach adolescents with information on a variety of topics, including ASRH, in a safe and informal space, alongside their peers and without fear of judgement. This approach to ASRH programming is just beginning to be explored in Bangladesh, but represents exciting potential for future programs.

Project Name
GOAL

Duration
2013 – 2015

Implementing Organization
BRAC

Funders
Women Win, DFID, AUS-Aid, Oxfam, NOVIB, UNICEF, British Council

The GOAL project, a partnership between BRAC Bangladesh and the Dutch organization Women-Win, was designed to use sports to promote the health and economic status of adolescent girls, in part through providing them with ASRH information. GOAL offers self-defense training in addition to other interactive sports in sessions that are accompanied by messages on menstruation, menstrual hygiene, and how HIV and STIs are spread, among other topics. These sessions provide in and out of school girls enrolled in the program a safe and informal space to ask their peers or mentors questions about their bodies without fear of judgment. GOAL also trains participating girls to be community sports instructors, who then train other girls in sports such as cricket, football, netball, karate, and self-defense. In the last three years, GOAL has reached more than 11,000 girls with sports and life skills training.

CASE STUDY 4

Capitalizing on Information and Communications Technology

With the high penetration of mobile technology in Bangladesh and high levels of use by young people, information and communications technology (ICT) is becoming more prevalent and is increasingly used as a conduit for reaching adolescents. BALIKA, Generation breakthrough, UBR, and Tarar Mela and SRHR-E have all employed ICT to reach adolescents with ASRH information. BALIKA used ICT for ASRH awareness building, skills building, and livelihood training (see below). Generation Breakthrough engages a youth audience in a range of social and health related topics through a weekly radio show 'Dosh Unisher Mor,' which takes adolescents' comments and questions via SMS. SHRH–E, UBR, and Tarar Mela all use toll free mobile phone services to provide ASRH information to adolescents through tele-counseling.

Program Name
BALIKA

Duration
2011 – 2016

Implementing Organization
Population Council

Funder
EKN

BALIKA (Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents) sought to prevent child marriage and improve life opportunities for girls in rural Bangladesh, in part through the application of ICT. The project, a four-arm randomized controlled trial, evaluated whether three skills-building approaches to empower girls can effectively delay the age at marriage among girls aged 12–18 in parts of Bangladesh where child marriage rates are at their highest. Girls in the program received one of three interventions: 1) tutoring in math-

Photo courtesy: Ashish Bajracharya, Population Council

ematics, English, and computing or financial skills training; 2) training on SRHR, gender rights and negotiation, critical thinking and decision making; or 3) training in entrepreneurship, mobile phone servicing, photography and basic first aid. The interventions were partly delivered via interactive applications on laptops and tablets. All girls met with mentors and peers on a regular basis in BALIKA centers (safe, girl-only spaces), which promoted friendships and additional learning opportunities. The trainings and meetings were designed to enhance girls' critical thinking and decision making skills and better equip them with the skills needed to navigate the transition from girlhood to adulthood. BALIKA was implemented through 72 BALIKA Centers in 3 districts (Khulna, Satkhira, Narail) of Southern Bangladesh, and reached 9,000 girls between 12 and 18 years old. BALIKA was implemented by the Population Council in partnership with the Population and Training Services Center, the Centre for International Development Issues, and mPower, with financial support from the Embassy of the Kingdom of the Netherlands.

CASE STUDY 5

Photo courtesy of Tousif Farhad, SSCOPE

Addressing Mental Health in ASRH Programming

Mental and emotional well-being are critical for adolescents' healthy transition to adulthood and closely tied to SRH, but have not received much attention in adolescent programming. This review identified one program, SSCOPE, that incorporates a focus on emotional well-being into ASRH programming.

Project Name
SSCOPE

Duration
2012 to date

Implementing Organization
BRAC-IED

Funder
EKN

SSCOPE (Schooling, Sexual and Reproductive Health and Rights, Gender and Counseling for Adolescents of Post-Primary Education) is a low cost, secondary education school model developed by the BRAC Institute of Educational Development, BRAC University (BIED, BRAC U). One of the unique elements of SSCOPE is the Sexual and Reproductive Health and Rights and Gender (SRHRG) curriculum and emphasis on the psychosocial development of adolescents. Recognizing the importance of addressing adolescents' emotional needs, SSCOPE includes SRHRG lessons and psychosocial counseling to provide adolescents with accurate information about their bodies and bodily rights and integrity, and a better understanding of their emotions. At present, SSCOPE is operating in 33 schools in nine different urban areas of Bangladesh.

CASE STUDY 6

Photo courtesy of Pathfinder International

Increasing Access to Health Services Through Adolescent and Woman Friendly Pharmacies

Ensuring that adolescents are able to access health information, services, and supplies without fear of stigma or discrimination is recognized as a central component of ASRH policies and programs. One program in this review (see below) is taking this approach in a new direction by establishing adolescent and women-friendly pharmacies. Looking at how health centers and services of all sorts can be made more accessible to and welcoming of adolescents could contribute to existing ASRH programming efforts.

Project Name
Surjer Hashi (Smiling Sun)

Duration
2012 to date

Implementing Organization
NHSDP/Pathfinder International

Funders
USAID, DFID

The adolescent- and woman-friendly Surjer Hashi (Smiling Sun) Pharmacy, operated by the Surjer Hashi clinic network, is an innovative health service delivery approach for improving the health of girls, women and their families by increasing girls' and women's comfort with and use of pharmacy services. As well as being a source for girls and women to purchase sanitary napkins, contraceptives and other reproductive health products without embarrassment, SH pharmacies will have a private space where girls and women can receive checkups and general and reproductive health-related medical services from female service providers. By employing female pharmacists and paramedics, the SH pharmacies will also create economic opportunities for women.

Programmatic Challenges

Lack of coordination between stakeholders and collaboration with the government

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

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

Non-traditional, age-appropriate interventions, such as sports-based interventions, the use of ICT, and game-based or interactive interventions have been used around the world to work with adolescents, including in SRH programming. These approaches may also be important entry points for young adolescents ages 10-14. Other interventions such as those that employ psychosocial counseling or mental health counseling or that involves parents were also rarely observed.

Limited rigorous evaluation and documentation of what works

Of the 32 reviewed programs, only three programs (BALIKA, SAFE, and Link Up) employed rigorous evaluation methodologies such as a randomized controlled trial or a quasi-experimental design to determine the impact and effectiveness of programs. Although many programs have done baseline assessments, they have not conducted rigorous impact evaluations. The majority of the programs used qualitative data to highlight success stories, but the inability to assess the impact of the interventions remains an inherent weakness of qualitative studies. Program documentation is a major challenge: if there is published documentation at all, it is generally not based on monitoring data, does not adequately describe what worked and what did not, and does not address implementation processes and challenges. Cost-effectiveness analyses and even cost data were largely unavailable. Most projects end with (relatively) simple reports, without rigorous evaluation processes. Lessons learned are primarily shared at meetings or through informal communication with program managers. This makes it difficult to measure a program's impact, even if it was innovative and apparently effective, and results in missed opportunities for future programs to learn from past experiences and avoid implementing approaches that have proven to be ineffective.

The significant financial investments that rigorous program evaluation requires can be a barrier. Moreover, during the design and budgeting phases, insufficient attention is given to incorporating programmatic evaluations, particularly rigorous ones. The consequence is that new ASRH programs aren't developed with evidence-based knowledge or an understanding of which components or approaches are best for addressing ASRH. Furthermore, without evaluation, there is no evidence for the optimal level of intensity and program duration needed to bring about sustained behavior change in the target group. Nevertheless, it is encouraging that there are increasing efforts to include such evaluation.

> ...a critical mass of programs must be rigorously evaluated and documented before any best practices can be validated and replicated or scaled up.

Given that rigorous research and evaluation in this field is limited, it is not yet possible to broadly define ASRH "Best Practices," which

require strong evidence of a program's ability to deliver significant positive outcomes for adolescents. This mirrors the situation globally, as rigorous evidence on programming for ASRH has been limited and is mixed when it does exist (see Hindin and Fatusi 2009). The three rigorously evaluated programs noted above, the results of which are promising, are paving the way for identification of best practices in Bangladesh. However, a critical mass of programs must be rigorously evaluated and documented before any best practices can be validated and replicated or scaled up.

Recommended Actions

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

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

Although multifaceted programs are increasingly employed in Bangladesh, they are still not the norm. This review suggests that multifaceted programs tend to be more inclusive and successful in addressing ASRH topics in the conservative Bangladeshi context. Multifaceted programs that combine sensitive ASRH issues with more acceptable themes and program approaches (e.g. livelihoods, empowerment, maternal health or the prevention of child marriage) can circumvent cultural and societal barriers.

Promising results are emerging from recent ASRH-focused programs that have employed a diverse set of interventions, including drawing from the health and legal sectors, employing innovative use of ICT and mass media, and using adolescent friendly channels to address issues as varied as eliminating GBV, improving SRH knowledge and practices, and preventing child marriage. Multifaceted programs also enable partnerships that can leverage the comparative advantages and strengths of implementing partners, and encourage coordination and camaraderie in a field that is crowded, competitive and prone to duplication of effort.

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

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

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

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

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

There is a dearth of strong evidence and documentation of whether ASRH programs in Bangladesh work, are cost effective, or have a positive impact on important adolescent outcomes. For example, although global

evidence does not indicate that peer-led models demonstrate significant impact to beneficiaries, this model is still frequently used in Bangladesh. Programmers should examine existing evidence, through a survey of the global literature, before designing or implementing interventions, to ensure that programs are based on the strongest available evidence. Reporting programmatic challenges or negative results should also be encouraged, since this is equally valuable information for the development of future programming.

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

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

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

Limitations

The review has some limitations.

First, it was based on document search for interventions addressing ASRH in Bangladesh. Although every effort was made to collect and collate available evidence on such programs, some interventions may have been excluded due to lack of documentation. In particular, the review found very limited documentation related to the capacity and attitudes of ASRH service providers, and was therefore unable to address this issue in depth. Given the significant impact these factors can have on adolescents' access to and experience of services, this is an area for future work. In addition, intervention components or details (e.g., length or type of health worker training, costs of services borne by beneficiaries, content of demand generation activities, and community-sensitization activities) were often not reported and may have influenced outcomes; we were unable to assess the impact of interventions not stated explicitly.

Second, publication bias and limited disclosure of negative results is an issue in any such review. As noted earlier, the review could not establish the robustness of the impact of some programs, since the reported effectiveness of the interventions depended on the quality of the evaluation approach used.

Third, the majority of the interventions reviewed used multiple strategies to reach the targeted beneficiaries. In most cases, the evaluation designs used did not assess the contribution of each strategy to the intervention outcomes. As a result, it was not possible to tease out the impact of each individual strategy.

Finally, not all research and evaluation designs were methodologically rigorous. Very few programs used randomized controlled designs (only two programs used RCT) and control groups were often not included in longitudinal studies, impeding the ability to attribute an outcome to a given intervention.

Many of the limitations encountered point to the pressing need for further research on how to best deliver adolescent SRH interventions and to determine which components are most effective.

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Appendix 1: ASRH Programs in Bangladesh, 2005-2015

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
ANGEL *Adolescents & Newlywed Girl's Events of Life* Part of larger USAID/DFID NGO Health Service Delivery Project	2013 – Present	USAID	NHSPD	NHSDP functions through 403 static and 10,482 satellite clinics managed by 26 NGOs throughout the whole country serving over 6 million adolescent and youth under this service delivery structure and the GOB assigned catchment areas.	ASRH Maternal Health	**Awareness Raising** Booklets for young people on puberty, child marriage, divorce, dowry, family planning, antenatal care, maternal health, postnatal care, abortion, infertility, impotency, HIV, STIs, condom use, and so on. Establishment of satellite clinic sessions in project catchment areas and awareness raising on related topics. **Service Delivery** Reproductive health and youth friendly services for adolescents and youth from 'Surjer Hashi' clinics, including tetanus vaccine, blood type testing, and hygiene-related information, and referrals for needed services.	Boys and girls 15-25 years old (unmarried, newly married and pregnant/ first-time parents)	Service statistics

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
APON *The Adolescent Peer Organized Network*	1998 – Present	UNICEF The Royal Netherland Embassy, NOVIB (OXFAM Netherland) The European Commission Aga Khan foundation CIDA, DFID	BRAC	58 regions in Bangladesh	ASRH FP Child marriage GBV	**Awareness Raising** Peer-led sessions on life skills and health-related issues with members of Kishori Club, secondary school students, madrassa students and out-of-school, working adolescents. **Community Mobilization** Sensitization of parents and community gate-keepers.	Adolescent girls, 10-19 years old	Quantitative: Survey of ADP graduates in year 2003, 2004 and 2005; results compared with national data of the Bangladesh Adolescent Survey (BAS) 2005. Qualitative: Case studies of ADP graduates.
ASHA *Addressing unmet need of SRHR for adolescents and youth through creating awareness in selected area of Bangladesh*	2014 – 2016	The Swedish Association for Sexuality Education (RFSU)	RHSTEP	2 districts: Sylhet & Khulna	ASRH	**Awareness Raising** SRHR education and awareness raising through discussion sessions and peer-to-peer activities. **Community Mobilization** 'Alor Dhara' community resource center organizes gatekeeper workshops, meetings, and parents' sensitization sessions on ASRH. **Services** Referrals to RHSTEP clinic. Counseling and tele-counseling services provided through 'Alor Dhara' (a youth friendly center).	Boys and girls, 10-24 years old	Service Statistics

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
ARSHI- ITSPLEY *The Innovation through Sport: Promoting Leaders, Empowering Youth project*	2009 – 2012	USAID	CARE Bangladesh	2 districts: Sylhet & Sunamganj	ASRH Child marriage GBV	**Awareness Raising** Use of role playing games to increase boys' understanding of the kind of difficulties girls undergo. Games include verbal and written dissemination of messages about life skills and prevention of child marriage. **Community Mobilization** Community/stakeholder sensitization campaign to create greater community acceptance of issues like girls' involvement in sport.	Adolescent boys and girls	Quantitative: End line survey in three program sites and one non-program site (for comparison). Qualitative: Focus group discussions with beneficiaries and program staff.
ASRHR *Adolescent Sexual and Reproductive Health Rights project in Disaster Prone Areas of Bangladesh*	2011 – 2013	Plan Bangladesh	South Asia Partnership (SAP) Bangladesh	6 Union Parishod (UPs) and 1 Pouro-shova in Barguna District	ASRH GBV	**Awareness Raising** Trainings and peer-led sessions for boys and girls on disaster preparedness and SRHR. **Community Mobilization** Training and counseling for parents, guardians, and school teachers. Adolescent support group meetings.	Adolescent boys and girls	Quantitative: Baseline, midline and end line surveys. Qualitative: interviews with beneficiaries and stakeholders.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
ASRYA *Access to Safe MR and Reproductive Health for Youths and Adolescents*	2014 – 2016	Safe Abortion Action Fund (SAAF), IPPF UK	RHSTEP	Several upazilas in 2 districts: Gaibandha & Brahmanbaria	ASRH Maternal health	**Awareness Raising** Education sessions at clinics and at safe spaces, through peer educators. **Services** ASRH counseling at clinics. Clinical services (primary health care, management of RTI/STIs, nutritional supplementation, and immunization) through RHSTEP clinics and by organizing satellite clinics.	Boys and girls, 10-24 years old	Service statistics

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
AVIZAN *Acceptance, Valuing, Information, Zero Tolerance, Advocacy, and Networking to promote adolescent sexual and reproductive health and rights*	1980 – Present	International Planned Parenthood Federation (IPPF)	FPAB	12 districts: Kushtia Comilla Jamalpur Dinajpur Faridpur Chittagong Tangail Patuakhali Sylhet Dhaka Barishal Rangamati	ASRH GBV	**Awareness Raising** Peer-led SRHR information sessions in safe spaces for adolescents and young people. **Community mobilization** Sensitization of parents, religious teachers, and school teachers on SRHR issues, so they will be prepared to share information with adolescent girls and boys. Workshops with parents and gatekeepers on ASRHR. **Services** Youth friendly services offered through Tarar Mela centers, including tele-counseling, face-to-face counseling, and skills development courses. Clinical services through static clinics, satellite camps and mobile medical services.	Boys and Girls, 10-24 years old	Service Statistics

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
BALIKA *Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents*	2012 – 2016	EKN	Population Council PSTC CIDIN mPower	3 districts: Narail Satkhira Khulna	ASRH Child marriage Livelihood	**Awareness Raising** Training on education, livelihood, gender rights, and negotiation in 72 "Safe Spaces." **Community Mobilization** Advocacy meetings, local support group meetings and courtyard meetings for parents, local leaders and stakeholders.	Adolescent girls, 12-18 years old	Quantitative: Randomized control trial; Experimental design. Baseline and end line surveys. Qualitative: Key informant interviews, focus group discussions and in-depth interviews; community assessment, girls' mobility mapping.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Creating an enabling environment for young people to claim and access their sexual and reproductive health rights in Bangladesh	2015 – 2019	European Union EPZA	Plan International Bangladesh Marie Stopes Bangladesh SAP Bangladesh Young Power in Social Action	3 districts: Barguna, Khagrachari, & Kishorganj	ASRH Maternal health	**Awareness Raising** Unmarried: Peer-to-peer approach to share information on adolescent reproductive health issues. Development of ASRHR modules for different age groups (10-14; 15-19; 20-24). Married: Peer-to-peer approach to raise awareness on maternal mortality, adolescent birth rate, contraceptive use, and antenatal care. **Community Mobilization** Coordination with Union Parishad-level standing committees and management committees. Sensitization campaign on HIV prevalence. Operationalization of National Action Plan on ASRH in the district level. **Services** Referrals to clinics.	Boys and girls, 10-24 years old	Quantitative: Baseline survey

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
DANIDA A+ *Improve Youth Friendly*	2011 – 2012	DANIDA A Plus Fund Denmark	FPAB	4 districts: Jessore Khulna Dinajpur Fardpur	ASRH FP	**Awareness Raising** SRHR sessions at Tarar Mela centers (safe space). **Services** Establishment of static clinics in urban areas to offer contraceptive counseling, STI/RTI services, and infertility services. Establishment of satellite camps to reach rural residents and domestic workers. SRH information and counseling through tele-counseling.	Boys and girls, 10-24 years old	*Insufficient documentation of evaluation mechanism*

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Generation Breakthrough	2012 – 2016	EKN	Plan International Bangladesh UNFPA MOE MOWCA CWFD BBC Media Action	4 districts: Patuakhali Barguna Barisal Dhaka	ASRH GBV Gender equity	**Awareness Raising** Implementation of GEMS (Gender Equity Movement in Schools) curriculum in schools and adolescent clubs. Dissemination of SRHR information through sports activities (planned). **Community Mobilization** Help line services will be offered 7 days a week on ASRHR, gender justice, and GBV. Radio program, "Dos Unisher Mor," on Radio Foorti. **Services** Delivery of youth friendly services through youth friendly units in clinics and health centers, for married and unmarried adolescents and young people.	Adolescent boys and girls, 10-19 years old	Quantitative: Baseline survey. Monitoring data on program implementation
GOAL: BYWLTS	2013 – 2015	Women Win DFID AUS-Aid OXFAM NOVIB UNICEF British Council	BRAC	4 districts: Narayanganj Khulna Sylhet Bogra	ASRH Child Marriage GBV	**Awareness Raising** Peer-led sessions for 4 GOAL modules, including ASRHR modules. Dissemination of ASRHR information through a variety of games. **Community Mobilization** Monthly parents' meeting. GOAL project-conducted gatekeeper workshops and training on ASRHR.	Adolescent girls, 11-18 years old	Quantitative: Baseline survey

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
IMAGE	2014 – 2016	EKN	Terre des Hommes Foundation SKS Foundation Pollisree	3 districts: Gaibandha Nilphamari Kurigram	ASRH Child Marriage	**Awareness Raising** Training, counseling and awareness building with early married girls, their spouses and in-laws. Orientation sessions with local health service providers and relevant stakeholders. Online knowledge modules on early married girls' issues, such as SRHR and life skills. **Community Mobilization** Organization of advocacy and lobby events to influence policy implementers, the private sector and government institutions. Development of documentaries, news, posters, TV spots, IEC materials, billboards, and so on.	Married adolescent girls under 18 years old	Quantitative: Baseline survey Qualitative: Focus group discussions; In-depth interviews; Key informant interviews
Kaishar *Adolescents reproductive and sexual health program*	2003 –2008	Nike Foundation	Save the Children USA	6 unions in Brahmanbaria	ASRH	**Awareness Raising** Community-based peer education on SRHR. **Community Mobilization** Advocacy and mass media activities. Workshops for parents and adults.	Adolescent girls, 10-19 years old	Quantitative: Baseline and end line surveys

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Kishoree Kontha	2006 – 2009	Nike Foundation	Save the Children USA	Barisal	ASRH Child Marriage Livelihood	**Awareness Raising** Dissemination of basic reproductive health education. Peer-led education to engage women in income generating activities through access to credit. **Community Mobilization** Sensitization of families and the community.	Adolescent girls, 10-19 years old	Quantitative: Randomized control trial design. Baseline survey and midline evaluation.
Kishori Abhijan *Adolescent Empowerment Project*	1st phase 2001 – 2005 2nd phase 2006 – 2010	European Commission UNICEF	BRAC CMES Save the Children Australia MOWCA	28 districts (rural): Panchagar Thakurgaon Nilphamari Lalmonirhat Dinajpur Kurigram Rangpur Gaibandha Joypurhat Sherpur Jamalapur Mymensingh Bogra Naogaon Nawabganj Rajshahi Natore Kushtia Dhaka Narshingdi Brahmanbaria Comilla Chandpur Laxmipur Feni Chittagong Cox's bazar Sylhet Barguna	ASRH Child Marriage Livelihoo	**Awareness Raising** Establishment of adolescent centers to provide livelihood training and life skills messages and social actions. Peer-to-peer participatory education and life skills training, focused on health and nutrition, SRHR, HIV/AIDS, STI, child marriage, dowry and GBV. **Community Mobilization** Orientation sessions and regular discussion meetings for parents and community leaders to increase awareness of the critical factors affecting adolescents' lives.	Adolescent girls, 10-19 years old	Quantitative: Baseline survey Monitoring data (routine records and field notes, parents' meeting minutes, structured checklist). Qualitative: Several tools (for example, social mapping and spatial mapping) were used to capture changes in behavioral indicators.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Link Up	2013 – 2015	Dutch Ministry of Foreign Affairs (BUZA)	Population Council HASAB Marie Stopes International Bangladesh (MSB)	8 brothels in 6 districts: Rajbari Jessore Patuakhali Bagerhat Tangail Faridpur	ASRH HIV	**Awareness Raising** Peer outreach to young people in the community on SRHR information, through one-on-one or group sessions. SRH information also offered at the drop-in center (a safe space model for key youth populations). Young people in garment factories are reached with SRH information through audio messages. **Services** Drop-in center offers referrals to MSI Bangladesh clinics when services are required. Strengthening and increasing HIV/SRH integration in Link Up facilities. Establishment of Marie Stopes Bangladesh satellite clinics.	Boys and girls, 10-24 years old	Quantitative: Baseline and end line surveys. Qualitative: In–depth interviews with target group.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Nirapod *Saving Women from Unwanted Pregnancy*	1st phase: 2012 – 2015 Nirapod second phase is ongoing	EKN	Marie Stopes Bangladesh Bangladesh Association for the Prevention of Septic Abortion (BAPSA) Phulki and Shushilan	21 selected Upazilas from six districts: Patuakhali Borguna Narail Khulna Lakxmipur Noakhali Chittagong 28 garment factories from Dhaka, Gazipur an Narayanganj	ASRH Child marriage GBV FP Maternal health MR	**Awareness Raising** Local-level media campaign (music and BCC materials). **Community Mobilization** Advocacy on gender issues, specifically prevention of child marriage and violence against women. Sensitization of key decision-makers, formal and informal leaders, and gate-keepers to promote men's supportive role in prevention of unwanted pregnancy and promotion of safe menstrual regulation. **Services** Referral services and helpline services for safe menstrual regulation, FP, and adolescent reproductive health.	Women, adolescents, and garment factory workers	Quantitative: Baseline, mid-line, and end line surveys. Qualitative: In-depth interviews and focus group discussions with beneficiaries. Key informant interviews with garment factory owners and management and government officials.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
P-SAFE *Promoting SRHR and Adolescent Friendly Environment*	2010 – 2013	RFSU The Swedish Association for Sexuality Education	FPAB	3 districts: Rangpur, Tangail, & Comilla	ASRH Livelihood	**Awareness Raising** Peer-led sessions on SRHR for young people in rural areas. **Community Mobilization** Sensitization activities with parents, religious teachers, and school teachers, to prepare them to disseminate information to adolescent boys and girls. **Services** Tele-counseling, face to face counseling, skills development courses. Establishment of static clinics, satellite camps, and mobile medical services. Contraceptive counseling, STI/RTI services, and infertility services offered through 'Tarar Mela.'	Boys and girls, 10- 24 years old	Quantitative: Baseline and midline survey with adolescents. Qualitative: Focus group discussions with adolescents Interviews with field level program staff.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
PHR *Protecting Human Rights*	2011 – 2016	USAID	Plan International Bangladesh The Bangladesh National Women Lawyers' Association (BNWLA)	102 unions in 6 districts: Barguna Bogra Chittagong Dinajpur Jessore Sylhet	ASRH Child marriage GBV	**Awareness Raising** Establishment of active community-based social protection groups to lead community activities focused on changing attitudes on domestic violence. Community Mobilization Advocacy for legislative reform and enforcement to reduce domestic violence. **Capacity Building** Capacity building of key stakeholders involved with the protection and promotion of human rights.	Women and children	Quantitative: Surveys with students and teachers. Qualitative: Focus group discussions and key informant interviews.
RHIYA *Reproductive Health Initiative for youth in Asia*	2003 – 2006	UNFPA	BDRCS CWFD BWHC FPAB MSB NM USS YPSA Save the Children-UK in partnership with SOLIDARITY	District towns: Sylhet Dhaka Khulna Rangpur Chittagong Rajshahi	ASRH	**Awareness Raising** Peer-led reproductive health sessions in school. Establishment of resource center in the community. Meeting with service providers. Reproductive health video sessions with adolescents. **Service Delivery** Counseling through 23 service delivery points. Youth friendly services.	Boys and girls, 10-24 years old	*Insufficient documentation of evaluation mechanism.*

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
RSHP *Reproductive & Sexual Health Program at rural, semi-urban and urban areas*	1981 – Present	BWHC	Bangladesh Women's Health Coalition (BWHC)	Narayangonj Tangail Norsingdi Lohagora Gaibandha	ASRH FP Maternal health	**Awareness Raising** BCC materials provided at clinics. **Services** Establishment of satellite health center, SHSPP integrated health centers, and fistula patient rehabilitation center.	Women, children and adolescent girls	Service statistics
SAFE *Growing Up Safe and Healthy*	2011 – 2014	EKN DANIDA MacArthur Foundation	ICDDR,B Population Council Marie Stopes BLAST We Can Campaign and NariMatiree	Urban Dhaka, 19 slums: Mohakhali Jatrabari Mohammadpur	ASRH Child marriage GBV	**Awareness Raising** Awareness raising sessions with adolescents, women's and men's groups on SRHR, child marriage and VAW. **Community Mobilization** Community-wide campaign on health and SRHR issues. Formation of community support groups and campaigns. Arrangement of plays, stage shows and concerts. **Services** One-stop services and SAFE hotline for SRHR services.	Adolescent girls, young women and men, 10-29 years old	Quantitative: Multisite cluster randomized controlled trial design. Baseline and end line surveys. Qualitative: Key informant interviews, in-depth interviews, and focus group discussions.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Sexual and Reproductive Health and Rights Program focusing on safe MR and reduction of unsafe MR in Bangladesh	1st phase 2010 – 2014 2nd phase 2015 – Present	SIDA and CordAid, Netherlands	RHSTEP	20 districts	ASRH Maternal health	**Awareness Raising** Clinic-based educational sessions and BCC materials on safe menstrual regulation. **Services** Comprehensive training on menstrual, SRHR, and youth friendly health services. Diagnostic services.	Men and women, 10-49 years old, with a special focus on 10-19 year olds	Service statistics.
Sishuder Jonno Program *Adolescent Development Component*	2008 – Present	Save the Children	Save the Children	Meherpur	ASRH Livelihood	**Awareness Raising** School- and community-based health education and ASRH sessions. Peer education sessions on ASRH, financial literacy and savings. **Community Mobilization** Sensitization of parents, teachers and community people through advocacy meetings.	Adolescent girls and boys, 10-19 years old	Quantitative: Baseline and midline surveys.

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Shokhi *Narir Sahstho, Odhikar o Iccha-puron*	2013 – 2017	EKN	BLAST Bangladesh Women's Health Coalition (BWHC) and Marie Stopes (MSB) We Can Alliance	15 slums in Urban Dhaka Mohakhali Mirpur Mohammadpur	ASRH GBV Livelihood	**Awareness Raising** Awareness and education sessions on SRH and legal rights and freedoms, targeting both women and men in the community. **Community Mobilization** Mobilization of communities through 'Change Makers,' volunteers who act as a focal person and link between service providers and the community. **Services** Health and legal information services through "One Stop Shops," along with doorstep and evening services. Establishment of linkages and referrals between government and non-government service providers to support women victims of violence.	Women and adolescent girls working in the garment and domestic sectors	Quantitative: Baseline survey

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SRHR-E *SRHR Education Bangladesh-Break the spiral of silence*	2012 – 2014	OXFAM-Novib	BRAC BNPS CAMPE FPAB HASAB	6 districts: Khulna Chittagong Jessore Netrokona Sylhet Rangpur	ASRH FP Maternal health	**Awareness Raising** Peer education and toll free mobile phone number for information. **Community Mobilization** Advocacy and lobbying for implementation of comprehensive SRHR curriculum in private schools. Edutainment (a mix of mass entertainment and community intervention) services to reach parents. **Services** Nationwide call enter and a local helpline to answer ASRH-related queries from adolescents and, if needed, referral to a doctor or hospital	Adolescent boys and girls, 11-19 years old	Qualitative: Interview with beneficiaries
SSCOPE	2012 – Present	EKN	BRAC-IED	1 district: Dhaka (9 locations in urban areas) in Urban Dhaka	ASRH Mental Health	**Awareness Raising** Sexual and reproductive health and rights and gender (SRHRG) and psychosocial lessons using dialogue, storytelling and art-focused methods. Dissemination of instructional materials and capacity building of teachers to increase students' motivation, engagement and interest in learning. **Services** Counseling services for adolescents on ASRH and psychosocial wellbeing.	Adolescent girls and boys, 10-19 years old	Qualitative: Interviews with beneficiaries and para-counselors.

Intervention	Year	Donor	Implementing Organization	Program Reach & Location	Project Theme	Approach and Project Description	Target Group	Evaluation Mechanism
Strengthening Adolescent Reproductive Health in Bangladesh	2008 – 2012	Canadian International Development Agency (CIDA)	Plan Bangladesh Concerned Women for Family Development (CWFD) Dustha Shasthya Kendra (DSK) Lutheran Aid to Medicine Bangladesh (LAMB) Marie Stopes Bangladesh (MSB) Population Services and Training Centre (PSTC) Radda MCH-FP Centre (RADDA) Young Power in Social Action (YPSA)	3 districts, both urban (city corporation) and rural areas: Dhaka Rangpur Chittagong	ASRH	**Awareness Raising** Life skills, peer education, leadership and gender trainings. **Services** Adolescent friendly health services and counseling services in a safe, supportive environment.	Adolescent boys and girls, 10-19 years old	Qualitative: In-depth interviews, key informant interviews, focus group discussions with direct and indirect beneficiaries and other stakeholders. Annual reports, MIS reports and project documents.

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Tanisha *Improving income and advancing social identity of rural adolescent girls*	2011 – 2013	SHIREE DFID	Save the Children USA	Barisal District	ASRH Child marriage Livelihood	**Awareness Raising** Peer-based trainings on financial management and income generating skills, children's rights, health and hygiene. **Community Mobilization** Peer groups organize community-benefit events addressing topics of interest to the wider community. These events provide an opportunity for girls to share what they are learning with their families and community members, while practically applying and demonstrating their leadership skills.	Adolescent girls,12-19 years old	Quantitative: Baseline and end line surveys.
Tipping Point	2013 – 2017	Kendeda Fund	CARE Bangladesh	2 districts: Sunamganj & Sylhet	ASRH Child marriage	**Awareness raising** Peer-led fun centers for adolescent boys and girls. Training manual on ASRHR, dowry and child marriage prevention (under development). Sports-based ASRHR and child marriage learning programs. **Community mobilization** Community dialogue for adolescent girls to raise issues of concern, like child marriage and dowry.	Adolescent boys and girls under 18 years of age	Qualitative: Process documentation and qualitative data

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UBR *Unite for Body Rights*	1st phase 2011 – 2015 2nd phase is ongoing	EKN	FPAB RH-STEP PSTC DSK and Christian Hospital Chandraghona	In several upzilas in 6 districts; urban area included: Mymesingh Bogra Rajshahi Noakhali Gazipur Chittagong	ASRH FP GBV Maternal health	**Awareness Raising** Peer-led SRHR sessions for adolescents and young people. Online ASRH and comprehensive sexuality education course, "Me and my world." **Community Mobilization** Sensitization workshop with parents, teachers and gatekeepers on ASRHR. **Services** Youth friendly services (through Tarar Mela) including tele- counseling and skills development courses. Establishment of static clinics, satellite camps and mobile medical services. Community-based distribution services for contraceptives, pregnancy tests, regular follow-up and referral services.	Boys and girls, 10-24 years old Married women 15-49 years old	Quantitative: Baseline survey. Qualitative: In-depth interviews and focus group discussions.

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