

LANDSCAPE REVIEW OF FAMILY PLANNING PROGRAMMING FOR ADOLESCENTS AND YOUTH IN BANGLADESH

PROGRAM APPROACH

FEBRUARY 2019

The aim of this review is to inform Shukhi Jibon's initial adolescent and youth program strategy. The project's Intermediate Result (IR) 2, "Increased Availability of Public Sector Family Planning Outreach Contacts and Services, Particularly for Adolescents and Youth" targets a group for which there are both significant programming limitations and opportunities in Bangladesh. This review was conducted to ensure the project's adolescent and youth strategy is grounded in a thorough analysis of the national picture of family planning programming for young people. This review first looks at the status of adolescent sexual and reproductive health



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and Government of Bangladesh's response to adolescent and youth (A&Y) family planning (FP) needs, including gender considerations. It then examines current data availability on FP topics relevant for A&Y (e.g., sexual debut, early marriage, marital sexual behavior, unwanted pregnancies, contraceptive availability and accessibility, contraceptive knowledge, and modern method contraceptive use). Following this, a description of the range of current A&Y programs implemented in project divisions is provided. The review concludes with an outline of potential opportunities for improving A&Y FP program reach and quality. Specific proposed activities aim to complement current initiatives, while advancing their alignment with international program standards in a culturally competent fashion.

STATUS OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN BANGLADESH

With a strong tradition of early marriage, against a backdrop of conservative social norms, A&Y reproductive health in Bangladesh has historically been overlooked in national family planning programs. This has resulted in a dearth of A&Y friendly FP programs; a lack of knowledge about A&Y sexual behaviors; lack of data on needs and effective interventions; and numerous policy, logistical and social barriers for married adolescents who wish to access contraception.

The Significance of Adolescence

Adolescents (aged 10-19) currently comprise more than 1/5 of the population. This proportion is expected to grow in the coming few years, and then begin to decrease as the youth bulge ages into adulthood. The adolescent period is characterized by impulsiveness due to adolescents' having a lesser developed prefrontal cortex than adults. It is also when young people pass through either a delayed or hastened transition into holding adult responsibilities—a divergence with life altering effects—that depends on adolescents' proximate opportunities and influences.

Delaying the need to hold adult responsibilities leads to greater rates of educational attainment, higher income, and significant health and education benefits for the next generation. In Bangladesh, it is customary to use the term adolescents to refer to unmarried young people. Once married, adolescents are considered

adults from a policy and social services perspective. In this review, however, we use the term to refer to all young people aged 10-19, whether married or unmarried. Though this differs from the typical usage in Bangladesh, it is technically accurate and in alignment with the standard public health definition. Bangladesh's relatively recent special focus on adolescent health aligns with the growing global pressure to invest in young people's health and wellbeing. A&Y health and wellbeing is critical for their progression into a productive adulthood, which thus has a positive influence on economic growth and national prosperity. Given Bangladesh's demographic transition—now beginning to wind down—maximizing economic growth is expected to yield dramatic intergenerational benefits to the population's health (Patton et al. 2016).

Marriage, Sexual Debut and Childbearing

Most females in Bangladesh marry and begin to bear children before reaching adulthood, thus incurring negative health consequences for themselves and their children. Current estimates identify marriage prevalence among 15-19 year old girls to be 44% (BDHS 2014). By age 18, the legal age of marriage for females, 59% of girls in Bangladesh are married. While the prevalence of marriage before age 16 declined between 2014 and 2018 from 35% to 32%, marriage before age 18 remained stable during this time (BDHS 2017/2018).

There is evidence though of potentially widespread inaccuracy of age reporting. While not reflected in the Bangladesh Demographic and Health Survey (BDHS) data, a study carried out by the International Centre for Diarrhoeal Diseases Research (ICDDR,b) identified a pattern of females underreporting their age at marriage from a few months to up to five years lower than their true age. While the study attributes this pattern to social and economic pressures related to dowry and dominant norms regarding a bride's age, level of education and 'purity', it also calls for more research into underlying factors (Streatfield 2015).

Adolescent marriage among boys is virtually non-existent, with males predominantly marrying after age 20. In urban areas, both adolescent females and young men marry about 1.5 years later than in rural areas. Among women 20-49, the median marriage age was reported to be 16.1 in 2014, though a higher median marriage age—17.4—was reported in City Corporation non-slum areas (UHS 2013). Significant proportions of

married adolescents report a desire to have married later (Chart 1).

There is very little information available about whether and in what context sexual debut among adolescent boys or girls may occur prior to marriage. National statistics about premarital sex do not exist, as married women consistently report their first sexual intercourse happening after marriage, and unmarried women are not asked about sexual behavior (BDHS 2014). However, various non-nationally representative studies have documented premarital sexual behaviors among both boys and girls (Amin et al. 2015; Li et al. 2010; Ahmed et al. 2005).

The median age at first birth among women 20-49 is 18.4, slightly over 2 years later than the median

In Dhaka, adolescent marriage and childbearing are higher, while TFR is lower; the reverse is observed in Sylhet

Division	Median Age First Marriage	Median Age First Birth	Adolescents Who Have Begun Childbearing	TFR
Dhaka	16.2	18.5	32%	2.2
Chattogram	16.8	18.8	26%	2.5
Sylhet	17.6	19.5	24%	2.6
Mymensingh	-	-	-	2.5

Table 1. Comparison of Median Marriage Age, Median Age at First Birth, Adolescent Childbearing, and Total Fertility Rate (TFR) in Shukhi Jibon Divisions | *Lowest = green, Highest = blue*

Adolescents' childbearing preferences indicate an ideal of two children, with about 1/5 of adolescent mothers indicating a desire for later initiation of childbirth (Chart 2).

Contraception: Knowledge, Use and Unmet Need

Most adolescents are able to mention at least one family planning method when prompted. However, the vast majority have limited knowledge about the range of contraceptive methods available, how to use them and where to obtain them. Nationally, 47% of married girls aged 15-19 use a modern method of contraception. In urban areas, modern method contraceptive use ranges from 51-54% (UHS 2013). Contraceptive use varies by division, with Sylhet and Chattogram having the lowest rates of contraceptive use in the country, and rates in Dhaka and Mymensingh mirroring the national average of 62% (Table 2) (BDHS 2014; BDHS 2017-2018).

Preferred Age at First Marriage

Key takeaways

- More than half of girls aged 15-17 would have preferred to marry later.
- Later marriage age is strongly associated with higher educational attainment.

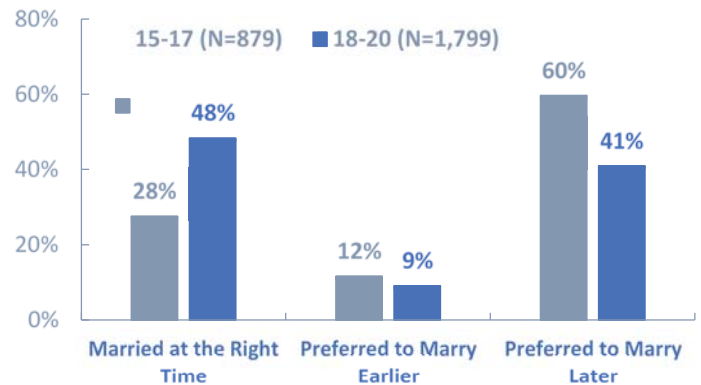


Chart 1: Ever married women 15-20, BDHS 2014

marriage age. By age 20, close to 70% of Bangladeshi females have already given birth. Notwithstanding, adolescent childbearing has shown an overall decline from about 1/3 (33%) in 2007, to 31% in 2014, and to 28% in 2018. Rates of adolescent marriage and childbearing vary by division (Table 1).

In Shukhi Jibon's intervention divisions, rates are 32% in Dhaka, 26% in Chittagong, and 24% in Sylhet (BDHS 2014). Mymensingh was still part of Dhaka Division when the 2014 Bangladesh Demographic and Health Survey was carried out.

Percentage of Births Wanted Later Than They Occurred, by Age Category

Key takeaway:

- One fifth of women under 20 would have preferred bear children later. This is higher than all other age categories.

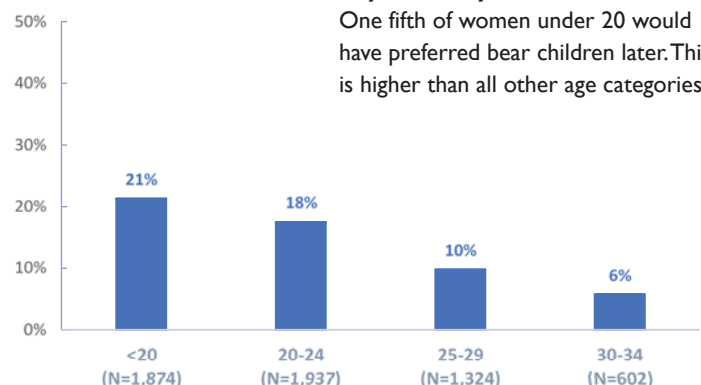


Chart 2. All births to women in the five years preceding the survey, BDHS 2014

Shukhi Jibon divisions, Sylhet and Chattogram, have the lowest contraceptive use rates in the country. Modern method use in Chattogram declined between 2014 and 2017/2018.

Division	Modern Method Use (2014)	Any Method (2014)	Modern Method Use (2017/2018)	Any Method (2017/2018)
Dhaka	54%	63%	-	62%
Chattogram	47%	55%	45%	54%
Sylhet	41%	48%	45%	55%
Mymensingh	-	-	-	63%

Table 2. Comparison of Contraceptive Prevalence Rates in Shukhi Jibon Divisions, 2014 & 2017/2018 (Lowest = green, Highest = blue)

Contraceptive Use Among Married Girls 15-19 (N=1,984)

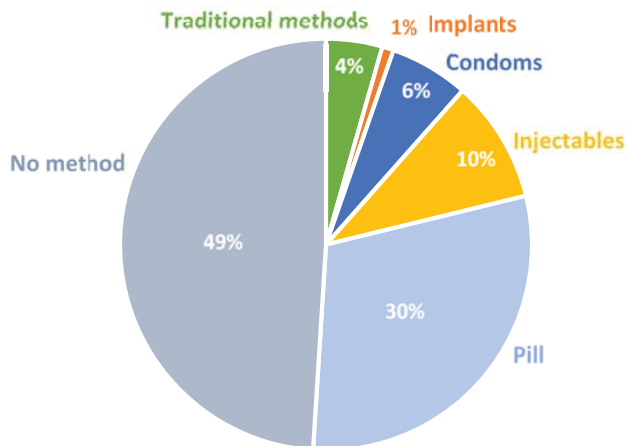


Chart 3. Percent distribution of contraceptive use by method among currently married females aged 15-19, BDHS 2014

The primary method used is the birth control pill, followed by injectables, and then condoms (Chart 3). About 4% of married adolescents use traditional methods and 49% do not use any method of contraception.

The birth control pill and condoms are most frequently sourced from pharmacies, though government field workers are also important suppliers of contraceptive pills. Injectables are commonly supplied both in the public and private sectors. The private sector—mainly pharmacies, but also private hospitals and clinics—is a fast-growing source of contraceptive methods. Private pharmacies are the main source for the Emergency Contraception (EC). While this option is available to anyone, and doesn't require a prescription, knowledge about EC is very low, with only 14% of

married women having ever heard of it in 2014 (BDHS 2014).

As compared to other age groups, married girls aged 15-19 report a higher prevalence of spousal separation due to work migration. The highest rates of married women who report having a husband who lives elsewhere are women (all ages) who live in Chittagong (24%), married women who have been married for less than five years, and girls aged 15-19 (19%). Among adolescents with a husband who lives elsewhere, 65% periodically see their husbands throughout the year. Possibly related to this, 22% of married females 15-29 who are non-users report that they do not intend to use contraception due to that they have infrequent or no sex with their partner. This dynamic may provide an opportunity for enhanced communication about effective condom use.

Married girls aged 15-19 have the highest unmet need for family planning (17%) compared to women of all other ages. This is five percentage points higher than the national average of 12%. At the same time, both knowledge and use of menstrual regulation (MR) are lower among adolescents than among adult women (BDHS 2014). A study published in 2017 found that the availability of MR services may be declining. The primary reason for this was identified to be a lack of training among newer, younger (i.e., aged 20-29) providers (Hossain 2017).



NATIONAL POLICIES AND PROGRAMS SHAPING FAMILY PLANNING SERVICE DELIVERY FOR ADOLESCENTS

Adolescent health is represented within a range of national legal and health policy frameworks, including the Child Marriage Restraint Act, the Child Labour Elimination Act 2010, the Education Policy 2010, the National Health Policy 2011, and the Bangladesh National Children Policy 2013. Perhaps the most significant policy framing family planning programs for adolescents is the Bangladesh Population Policy 2012. This policy has the specific objective of raising awareness among adolescents about family planning. However, it avoids mention of FP services for adolescents, instead emphasizing the need to prevent early marriage (Bangladesh Population Policy 2012).

In 2017, the Ministry of Health and Family Welfare (MOHFW) published the National Strategy for Adolescent Health 2017-2030 for the first time outlining its adolescent health priorities in detail. The Strategy focuses on four core areas—sexual and reproductive health, gender-based violence, nutrition and mental health (National Strategy 2017). Its associated Action Plan, a framework for implementing the Strategy, was approved in January 2019. A central component of the Strategy and Action Plan is the establishment of Adolescent Friendly Health Corners (AFHCs) within existing Maternal and Child Welfare Centers (MCWCs) and Union Health and Family Welfare Centers (UH&FWCs) (Action Plan 2019). As of February 2019, 403 AFHCs had been established and plans were underway for hundreds more.

In addition to this, the Directorate General of Health Services (DGHS) is overseeing an Adolescent and School Health Program (2017-2022). Though this is a national program, it is focusing initially on Shukhi Jibon divisions Chattogram and Sylhet. Its aim is to introduce a school-based health care package for adolescents covering the core components of the National Strategy. The intervention strategy intends to include outreach visits from health facilities to schools (Williams 2018).

Bangladesh's Prioritized Actions 2018-2020, part of its Family Planning 2020 commitments, details significant actions toward advancing family planning for adolescents. Its Commitment #5 includes the language, "Bangladesh will fully operationalize its new National Adolescent Health Strategy with special focus of addressing the family planning needs and promoting rights of all adolescents. Adolescents in Bangladesh will have access to widest range of family planning methods possible and special efforts will be made to track adolescent health data."

This document further outlines root causes of challenges related to this Commitment, and the actions required to

address them. These include further analysis of 2017/2018 BDHS data with a focus on adolescents, in service training for service providers on youth friendly services that target each adolescent and youth age category (10-14; 15-19; 20-24; 25-29; 30-34), and sensitization among young people, gatekeepers and other stakeholders on contraceptive options and appropriate method-mix (Prioritized Actions 2018).

Despite this, none of the new adolescent focused health initiatives has a strong focus on family planning. One reason for this is that FP services do not fall under the responsibility of DGFP's MCH Services Unit or the DGHS, which are responsible for overseeing the new adolescent health programs. Instead, contraceptive services are managed under the DGFP's Clinical Contraception Service Delivery Program (CCSDP) and the Field Service Delivery Program (FSDP). Both these units oversee the distribution and promotion of contraceptive methods, with FSDP having a larger role in directly promoting contraceptives to (married) adolescents and youth.



Multiple additional limitations exist in the policy framework regarding adolescent family planning. The most significant is the stipulation in the Population Policy that contraceptives will be provided to "eligible couples," to the exclusion of young people who are not married. Unmarried adolescents may receive information about family planning, but not services. The national Family Planning Guidelines 2011 specify that for married adolescents, the type of contraception

available to them is restricted based on whether or not they have begun to bear children. Newlyweds without children are offered the birth control pills, condoms and implants. Intrauterine devices (IUDs) and injectable contraceptives are only offered to married women who have already had one child. With a doctor's written permission, though, a married woman without children can obtain an IUD. Permanent methods are only available to those who have had two children.

With support from UNFPA and WHO, CCSDP has recently published a set of high-quality training tools and job aids for FVWs on family planning methods, as well as an information brochure on FP methods for newlywed couples. CCSDP leadership has expressed interest in making them available to adolescents through existing AFHCs. Also with UNFPA's support, in 2017 the FSDP, together with ICDDR,b, piloted an intervention Brahmanbaria district to provide family planning kits to newlywed couples. Kits contained condoms and a one month's supply of contraceptive pills, as well as information about how to use each of these methods. Implementation entailed establishing a coordinating mechanism between local Imams, marriage registrars ('Kazis'), and Family Planning Inspectors to track upcoming weddings and provide newlywed couples with a kit on the day of their marriage. Imams were involved because marriages are often carried out at home in traditional ceremonies prior to being registered, so this was thought to ensure kits would be received by couples prior to initiation of sexual intercourse.



While the intervention aimed to reach 19% of newlywed couples in the district, it successfully reached 16%. Overall, the intervention and the kits were well received by all stakeholders, however, some reticence was expressed by

local Imams. To address this, it is suggested that the Islamic Foundation or other influential religious leaders communicate about the intentions of the intervention to convince local Imams of its value (ICDDR,b 2019).

Gender Considerations

The concept of gender equity is interwoven into family planning in various ways. Discrimination on the basis of sex can limit women's power and agency in accessing contraception. At the same time, biased social norms tend to distance men and boys from involvement family planning discussions and decision-making, as reproductive health is frequently considered primarily a women's issue (MEASURE Evaluation 2017).

The evidence base on work with men and boys in sexual and reproductive health (SRH) programs is not yet well developed. Yet, the topic is increasingly being examined from multi-dimensional angles. For example, in a 2015 issue of the journal *Culture, Health and Sexuality*, the authors argue that while male involvement in SRH programs is typically considered to be a positive intervention result, it is not necessarily linked to gender norm transformation.

Furthermore, numerous male involvement programs use language that appeals to a dominant view of masculinity, such as "Man Up Monday" an intervention designed to encourage STI testing among men. While this type of program has demonstrated short-term health results, researchers argue that they also reinforce traditional notions of masculinity, which are harmful for both men's and women's health and wellbeing (Gibbs et al. 2015).

A recent Population Council paper looked more closely at how well men and boys are served by family planning programs globally. It found that men's and boys' contraceptive needs are inadequately addressed (Hardee et al. 2017). The authors offer the following "Key considerations in programming for men as family planning users":

- Provide information and services to men and boys where and when they need it
- Address gender norms that affect men's use of contraceptive methods
- Improve couple and community communication
- Meet men's needs while respecting women's autonomy
- Link men's family planning use with their desire to support their families
- Teach adolescent boys about pregnancy prevention and healthy sexual relationships
- Develop national policies and guidelines that include men as family planning users
- Scale up programs for men
- Fill the gaps through monitoring, evaluation, and

implementation science

- Create more contraceptive options for men

It is also well established that greater gender equality is also associated with higher contraceptive use rates. On one hand, it increases women’s access to contraception by removing social and structural barriers to family planning services. On the other hand, it leads to women’s empowerment by enabling women to dedicate more of themselves to education and income generation rather than reproduction and caregiving (Population Reference Bureau 2012).

Further to this, family planning counseling interventions offer opportunities for screening and referral to gender-based violence (GBV) services. Incorporating intimate partner violence (IPV) screening, first line treatment and formal referral into clinical settings is recommended by the World Health Organization (WHO) when assessing conditions that may be caused or complicated by IPV. Such conditions are

varied and range from depression, unexplained chronic gastrointestinal symptoms, and having an intrusive husband or partner in consultations to unexplained reproductive symptoms (e.g., pelvic pain), adverse reproductive outcomes, and suicidality or self-harm (WHO 2013).

The 2010 USAID Gender Assessment provides relevant guidance for ensuring gender-transformative approaches are integrated into Mission-funded projects across all sectors. It recommends applying the following tool (Box 1) to do so. In family planning interventions, it also specifically suggests increased sharing of information about male contraceptive methods (male condom, vasectomy, withdrawal and the Standard Days Method), and using peer education, men-to-men group discussions, male only clinic hours, the media to challenge traditional notions of masculinity and men’s roles, and support models of “positive deviance” (Britt et al. 2010).

Box 1 Gender Integration Tool		
Project Activity	Some Key Questions	Observations
Analysis	<ul style="list-style-type: none"> • Who benefits from the activity and how? • What are the implications for gender relations? • What opportunities exist for improving gender equity? • What are the specific criteria for understanding the impact on gender relations/social change? 	Think about context: especially, how power relations within the private sphere (household) relate to those in the public sphere (e.g., project, market, community, state).
Implementation	<ul style="list-style-type: none"> • Who participates? • What are the differences in the rate and quality of participation? • What will be the effect on men and women in the short and longer term? • What is being done to address inequalities? • Does the project adversely affect gender relations? • How might the project be adjusted to increase gender positive or transformative effects, and reduce or eliminate negative outcomes? • Are GIOs being maximized? 	<ul style="list-style-type: none"> • Are project personnel aware of and sympathetic towards women’s needs? • Do staff understand the meaning of gender, and are they sensitive to gender concerns and the importance of gender equity? • Are there opportunities for women to participate at the management level? • Do female staff deliver goods or services to women beneficiaries? • Are there mechanisms to ensure that resources or benefits are not usurped by males?
Monitoring and Evaluation	<ul style="list-style-type: none"> • How is progress being measured? • What indicators best reflect: (1) desired results, (2) differences (changes in baseline) and (3) the overall impact on gender relations? • Are proxy or process indicators being used to measure the impact of activities on gender relations, and the extent to which women’s equity needs are being met? 	<ul style="list-style-type: none"> • What is being monitored and/or measured? <i>Practical needs</i> (e.g., basic needs for food, water and shelter, healthcare, paid work) <i>and/or strategic needs</i> (e.g., changes to the division of labor, higher education, leadership skills, opportunities for collective action, increased decision-making removal of discriminatory laws, health choices that give women greater control over their bodies, measures to counter violence against women).

DATA FOR PROGRAM MONITORING AND EVALUATION

Currently, the most recent national statistics on adolescent sexual and reproductive health (SRH) are represented in the Urban Health Survey 2013, the Bangladesh Demographic and Health Survey (BDHS) 2014, the Report on Bangladesh Sample Vital Statistics (referred to as 'SVRS' for Sample Vital Registration System) 2016, the Bangladesh Maternal Mortality Survey (BMMS) 2016, and the BDHS 2017/2018. However, there are notable discrepancies between the 2016 SVS and the 2014 BDHS surveys on certain key measures. For example, the SVRS reported marriage prevalence among 15-19 year old girls to be 23% in 2016, while the 2014 BDHS reported it to be 44%. This difference is too great to be a trend.

Modern method contraceptive use among 15-19 year old females is reported in the SVRS to be 59% in 2016, while it was 47% in the 2014 BDHS, also too great of a difference to be considered a trend. A probing of lead

national survey specialists revealed that greater transparency exists about the methodologies used for the BDHS surveys than for the SVRS. This indicates that, in general, there is more confidence in the BDHS results than in the SVRS results.

Other limitations in availability of data are present as well. While the 2017/2018 BDHS preliminary results have been published, the detailed results were not available at the time of this report. Therefore, the national statistics presented below are already somewhat outdated. Another constraint is that the 2016 BMMS survey results have not yet been endorsed by the Ministry of Health and Family Welfare (MOHFW). Thus, while they are broadly accepted by development partners, constraints exist when it comes to discussing them with MOHFW counterparts and in justifying their use for program planning.



EXISTING NGOS AND PROJECTS PLAYING KEY ROLES IN FAMILY PLANNING FOR ADOLESCENTS AND YOUTH

The following organizations and projects are key players in the delivery of family planning programming for adolescents and youth in Shukhi Jibon program divisions. The project should explore ways to coordinate and collaborate with their programs.

Organization	Project	Shukhi Jibon Divisions	Program Description	FP Info	Services	Other
Family Planning Association of Bangladesh	AVIZAN	Dhaka, Chattogram, Sylhet	Static clinics and mobile teams, community sensitization	✓	✓	
Adolescent and School Health Program	DGHS	Chattogram and Sylhet	Health education in schools, service linkages	✓		
ADOHEARTS	UNICEF	Dhaka	AFHCs, HMIS, research, training materials/ job aids	✓		✓
Advancing Universal Health Coverage (AUHC)	Chemonics International Inc.	Dhaka, Chattogram, Sylhet, Mymensingh	Essential Services Package in urban clinics + outreach	✓		
FP in Bangladesh - Ensuring Quality and Coverage	Ipas	Dhaka, Chattogram, Sylhet, Mymensingh	Strengthen MR, PAC and FP in urban hospitals and pvt. clinics		✓	
Manoshi	BRAC	Dhaka, Chattogram, Sylhet, Mymensingh			✓	
Safe MR Project	RHSTEP and BAPSA	Dhaka, Chattogram Sylhet, Mymensingh	MR and FP in public hospitals + school and community outreach	✓	✓	
Unite for Body Rights II	RH Step	Chattogram, Mymensingh	Youth friendly health centers	✓	✓	✓
UPHCSDP II	MOLGRD&C	Dhaka, Chattogram Sylhet, Mymensingh	Primary health care services	✓	✓	✓

EXISTING NGOS AND PROJECTS PLAYING KEY ROLES IN FAMILY PLANNING FOR ADOLESCENTS AND YOUTH

Be Creative in Providing Family Planning Information to Unmarried Adolescents

International law and best practice guidance clearly consider the denial of contraception based on marital status to be a breach of adolescents' right to family planning services. There is a small but growing body of literature documenting pre-marital and extra-marital sexual behaviors in Bangladesh. This literature is essential to carefully building a case (with a long-term vision) to health administrators and policy makers of the importance of enabling access to contraceptives for unmarried adolescents.

In the absence of such a rights-based policy, there is an urgent need to employ creative and strategic programming efforts to reaching unmarried adolescents with actionable family planning information. Currently, various methods are being employed to target contraceptive use programs to newlywed couples. However, there is a significant limitation to these programs in that if contraceptive usage does not begin immediately after marriage, the opportunity to delay the first pregnancy may be lost.

To address this, it may be effective to shape training messages to providers around adolescence being a special time in which learning about contraceptive options is an important component of preparing for a healthy married



life. With this frame, providers, parents, community members and "gatekeepers" may be more open to having conversations with unmarried adolescents—as well as with other adults—about the need for adolescents to fully learn about contraceptive options prior to marriage. Learning materials should frame the late adolescent period (15-19) as a continuum of learning, discussions, decision-making and action.

A visual depiction of the continuum, with key roles for the individuals who shape adolescents' opportunities, may look like:

Information to Action Continuum for Unmarried Adolescents

Initial Learning

Unmarried adolescents and key adults receive comprehensive information about family planning options for married adolescents, adolescents' right to contraception, where/how to obtain contraceptives, and the importance of adolescents thinking about their childbearing preferences, even if they are not yet married

Adolescents should receive specific guidance for how to talk about their preferences regarding childbearing to their parents and other key adults in a culturally competent fashion, as discussions about and preparations for marriage by family members begin to occur

Adults should be informed about where and how short- and long-acting contraceptives can be obtained, and the benefits of young newlyweds using long-acting methods to delay pregnancy

Deepen Knowledge for Decision-Making in Preparation for Marriage

Unmarried adolescents receive guidance and tools to help them consider which forms of contraception might be best for them after they are married

Providers, parents, teachers and "gatekeepers" receive guidance on ways to passively or actively encourage young people to inform themselves and be ready to choose a contraceptive method to use once they are married

Initiate Contraceptive Use Immediately Following Marriage

Married adolescents begin using a contraceptive method of their choice immediately following marriage as a result of having already been informed about options and given an opportunity to consider which options they might prefer

Focus on Getting High Quality Family Planning Information into Adolescents' Hands

There are significant opportunities to improve adolescents' access to high quality information about family planning. None of the tools reviewed in this assessment had the kind of detailed information about family planning options and considerations that young people need in order to make timely, informed family planning decisions. The project should explore developing visually appealing, durable (i.e., able to withstand dust and/or water and stay intact), portable brochures that can be disseminated to adolescents via AFHCs, FWVs, community groups, schools, and marriage registrars.

Younger adolescents may be drawn to a question such as, "Do you know everything you need to know to be healthy and strong? Fun tips for growing stronger."

Unmarried girls and boys who are aware of the prospect of marriage in the relatively near future may be drawn to a brochure with the question, "Is marriage in your future? Here is what you need to know."

A question such as, "Young men, what are the most powerful things you can do to take care of your new bride?" may draw the attention of newlywed boys and young men.

A brochure for newlywed couples may have an attractive image of a happy young bride and groom with the statement, "Ready to start building a prosperous future together? What you can do as a couple to ensure a long and happy life together?"

An initial attention getting message for girls who have already had their first child may be, "Healthy Mommy, Healthy Baby," and for boys and young men, "New Father? Read this."

Ideally, brochures should include specific and comprehensive information about all contraceptive methods. In addition to this, consideration should be given to framing brochures with guiding questions, statements and images targeted at different groups of adolescents. For example, adolescents may be grouped into different audience segments based on a review of knowledge levels, needs, preferences and/or limiting beliefs, as well as gender, age and marital status.

Brochures should describe not only how each method works, but how effective it is, where it can be obtained, and what the policy limitations around it are. They should also include tips for accessing highly effective long acting methods, particularly for situations when a potential user does not live near a facility that provides them. Tips may include where and how long acting methods can be obtained, as well as suggestions for navigating the softer access barriers related to females' limited mobility and provider bias.

Examples of possible tips for navigating soft barriers include:

- 1 How to construct an argument for why a husband or other family member should escort a young woman to a facility where she can obtain Implanon or an IUD.
- 2 How to justify to family members the need for a long acting method over the much more widely available birth control pill.
- 3 How to assert one's right to a long acting method to a provider attempting to dissuade or prevent access based on misinformation or poor judgement.
- 4 What women's rights are regarding confidentiality of her health information.

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Accelerating Universal Access to Family Planning Project (AUAFP)

Accelerating Universal Access to Family Planning (AUAFP), also known as Shukhi Jibon, is a United States Agency for International Development (USAID)-funded project in Bangladesh, implemented by Pathfinder International in partnership with IntraHealth International, with strategic support from the Obstetrical and Gynecological Society of Bangladesh, the World Health Organization, and the University of Dhaka. The main objectives of this project are to increase the qualified family planning (FP) workforce to expand access to quality FP services through a collaborative health system capacity-building partnership with the Government of Bangladesh.

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The Adolescence Landscape Review was done by Anna Williams, a consultant hired by USAID Shukhi Jibon project - implemented by Pathfinder International and partners, to understand the current family planning and reproductive health services status for the adolescents in Bangladesh and to identify the scopes of gender integration in those services.

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