Special Publication

Proceedings of the First Stock-taking Workshop on ADOLESCENT HEALTH ACTIVITIES IN BANGLADESH

Held on October 27, 1998







Documentation

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Quamrun Nahar
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Jointly Organized by
ESP-Reproductive Health, Directorate of Family Planning
and
Operations Research Project
International Centre for Diarrhoeal Disease Research, Bangladesh

January 1999

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ICDDR, B Special Publication No. 88

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Foreword

The programme of action of the International Conference on Population and Development (ICPD) identified adolescents as a vulnerable group. In the Action Plan of the ICPD, it was suggested that the government, in collaboration with non-government organisations, should aim to meet the special needs of adolescents. In Bangladesh, adolescents constitute 23 percent of the total population. In the past, however, the National Health and Family Planning Programme did not place proper emphasis on adolescents. Therefore, the challenge, now, is for us to honour our global commitment by meeting the special needs of this segment of population.

The Government of Bangladesh is committed to improving adolescent health – one of today's a most important health agenda. Adolescent health has similarly been included in the Health and Population Sector Programme (HPSP). In fact, adolescents are now receiving the attention it really deserves.

To reinforce this level of commitment, the "First Stock-taking Workshop on Adolescent Health Activities in Bangladesh" is a timely one. During this workshop, we have been able to take stock of what has been done from the government side as well as from the private and NGO sectors. The objectives of the workshop were to allow different organisations working with adolescents to share the experiences they have gained and the lessons they have learned. It is hoped that the knowledge gained from the workshop will facilitate the design of strategies to more effectively address the health needs of Bangladesh's adolescents.

At this workshop, the government and NGOs have shared their experiences in delivering services to adolescents. They have discussed methods they have used to motivate people and the difficulties they encountered in implementing their programmes. It would be worthwhile for the national programme to heed this valuable information. Through such resourcefulness and cooperation we will be able to meet the challenges of the coming years.

Over the past two decades, ORP and its predecessor projects have been providing research input in the government programme. Its various operations research interventions have examined the issues we face in the national programme. Identifying the most critical needs of the adolescent will take initial precedence in ORP's activities, since such information will be essential for the design of a programme that will successfully serve this group.

The cooperation that has been demonstrated during this workshop – between the officials of the two directorates, NGOs and the ORP of ICDDR,B – is a clear indication of a good start for the adolescent programme. I am very grateful to ORP for jointly organising this workshop with my directorate. ORP is our valued partner. I would like to express my heartfelt appreciation to them, particularly for their contribution to the success of the national programme.

I appreciate the efforts and commitment made by the GoB, NGOs, other relevant organisations and USAID to make the workshop successful. We hope to continue similar activities to help strengthen the national adolescent health programme. I recommend this document to all who work with us and are committed to making the adolescent programme a success.

Md. Shirajul Islam
Director General
Directorate of Family Planning

Acknowledgements

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- International organizations: International Atomic Energy Agency (IAEA), International Center for Research on Women (ICRW), International Development Research Centre (IDRC), Population Council, Swiss Red Cross, and the World Bank;
- Foundations: Aga Khan Foundation, Child Health Foundation, Ford Foundation, George Mason Foundation, and Rockefeller Foundation;
- Medical research organizations: International Life Sciences Institute (ILSI), National Institutes of Health (NIH), New England Medical Center, Northfield Laboratories, Procter and Gamble, Rhône-Poulenc Rorer, and Thrasher Research Fund;
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First Stock-taking Workshop on Adolescent Health Activities in Bangladesh

October 27, 1998
Time: 8:30 am - 2:00 pm
Venue: Sasakawa Auditorium, ICDDR,B

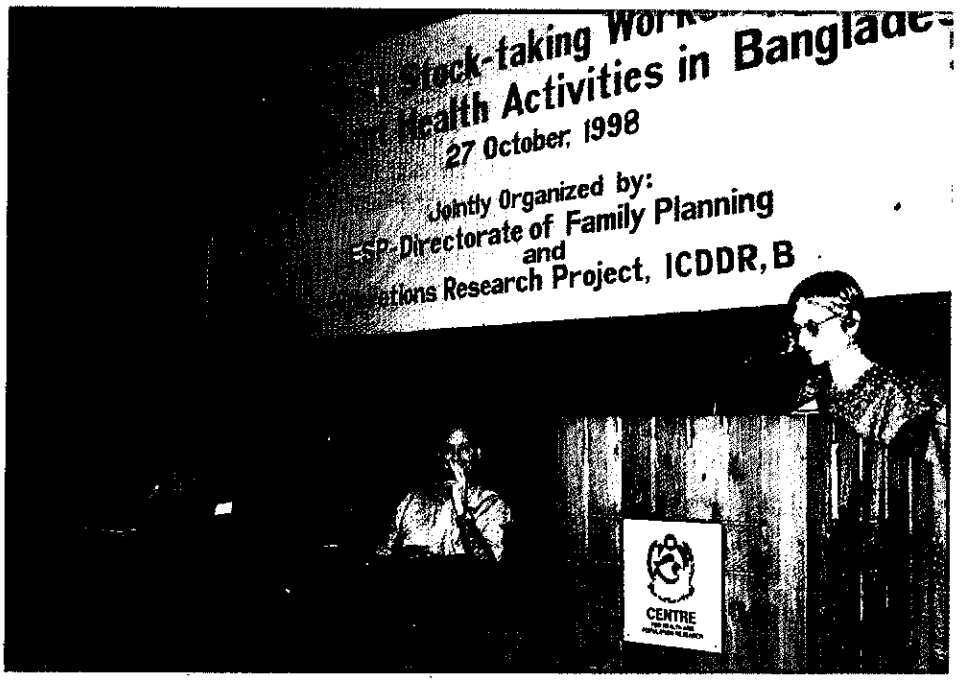
Organized by:
ESP-Reproductive Health
Directorate of Family Planning
and
Operations Research Project, ICDDR,B

Programme

Time	Activity
Inaugural Session	
08:30 - 08:55	Registration
08:55 - 09:00	Recitation from the Holy Quran
09:00 - 09:15	Welcome address by Dr. Jahir Uddin Ahmed, Director-MCH Services and Line Director, ESP
09:15 - 09:30	Inaugural address by Chief Guest: Prof. A.K.M Nurul Anwar, Director General, Health Services
09:30 - 09:50	Tea
Working Session	
09:50 - 10:05	An overview on adolescent health status and the existing adolescent health programmes in Bangladesh by Dr. Rafiqus Sultan of DFP and Dr. Quamrun Nahar of ORP, ICDDR,B
10:05 - 10:15	Presentation on Government School Health Programme by Dr. Khaled Shamsul Islam, School Health Pilot Project
10:15 - 10:30	Presentation by Dr. Shamsher Ali Khan , BRAC
10:30 - 10:45	Presentation by Ms Shahin Akter Dolly, Nari Maitree
10:45 - 11:00	Presentation by Ms Fatema Alauddin, FDSR
11:00 - 11:15	Presentation by Ms Mubarra Matin, CWFP
11:15 - 11:30	Presentation by two adolescents
11:30 - 12:15	Discussion
Closing Session	
12:15 - 12:30	Rapporteur's report
12:30 - 12:40	Address by: Professor Barkat-e-Khuda, Chief of Party, ORP, and Division Director (A), HPED, ICDDR,B
12:40 - 12:50	Address by: Professor George Fuchs, Interim Director, ICDDR,B
12:50 - 01:00	Address by: Ms Margaret Neuse, Team Leader, Population and Health Team, USAID
01:00 - 01:10	Address by Special Guest: Dr. Shamsul Haque, Director-PHC and Line Director- ESP
01:10 - 01:30	Address by Chief Guest: Mr. Md. Shirajul Islam, Director General, Family Planning
01:30 - 01:40	Address by Chairperson: Dr. Jahir Uddin Ahmed, Director-MCH Services and Line Director, ESP
01:40 - 02:00	Lunch

Contents

Appendices:



Ms Margaret Neuse, Team Leader, Population and Health Team, USAID delivering speech in the workshop

A partial view of the discussion session of the workshop

Background

The Programme of Action of the International Conference on Population and Development (ICPD), held in 1994 in Cairo, identified adolescents particularly as a vulnerable group. The Programme of Action also suggested that governments, in collaboration with non-government organizations, should meet the special needs of adolescents. But as of today, relatively very little effort has been directed at meeting the adolescent health needs in Bangladesh.

In the past, the government health and family planning programme has primarily targeted the married women of reproductive age and children, thereby largely ignoring the health needs of adolescents. Although different non-government organizations have taken a few initiatives aimed at addressing the reproductive health and other needs of adolescents, these activities were rather uncoordinated, poorly documented, inadequately evaluated, of relatively small scale, and were pilot efforts with limited impact.

Given the large number of adolescents, who will be reaching reproductive age during the next few years and their limited access to health services, the Government of Bangladesh and the National Integrated Population and Health Programme (NIPHP) have identified adolescents as a priority target group. Adolescent health has been recognized as a priority in the Health and Population Sector Programme (HPSP), the country's new five-year strategy for health and family planning. Thus, adolescent health has been covered under the umbrella of the Essential Services Package (ESP). A separate programme referred to as "Maternal Nutrition and Adolescent Health" has been initiated under the "Reproductive Health" component of ESP. All health and family planning service providers in the public sector will be engaged in the delivery of adolescent health services as a sub-component of Reproductive Health Care. ICDDR,B, UNICEF, UNFPA, and WHO have been helping the government to formulate a well-planned strategy regarding adolescent health.

With the above scenario in view, the Maternal Nutrition and Adolescent Health Programme of the Directorate of Family Planning, in collaboration with the Operations Research Project (ORP) of ICDDR,B, organized the "First Stock-taking Workshop on Adolescent Health Activities in Bangladesh" on October 27, 1998 at the Sasakawa Auditorium, ICDDR,B. Agencies involved in adolescent programmes in the country (both government and NGOs) shared their experiences at the workshop. Two adolescents engaged in special adolescent programmes of the Concerned Women for Family Planning (CWFP) and the Family Development Services and Research (FDSR) also shared their experiences with the audience.

Objectives

The objectives of the workshop were:

i. To allow different organizations to share experiences they have gained and lessons they have learned in their work with adolescents; and

ii. To help design strategies to address future health needs in the context of Bangladesh.

Inaugural Session

Inaugural Address by Dr. Jahir Uddin Ahmed
Director-MCH Services and Line Director, ESP
Directorate of Family Planning

Ladies and Gentlemen, I welcome you all at this "First Stock-taking Workshop on Adolescent Health Activities in Bangladesh." We have learned that the Director General, Health Services, who was supposed to be the chief guest at this inaugural session, needed to go to the Ministry to attend an important meeting with the honourable Minister of Health and Family Welfare. Even though he is unable to join us today, we are very much grateful to him for accepting our invitation to be the chief guest in the inaugural session.

As you know, Bangladesh government launched a comprehensive Health and Population Sector Programme (HPSP) in early July 1998. The most important component of the HPSP is the Essential Services Package (ESP). You know that there are two Line Directors for the ESP, one in the Directorate of Family Planning and another in the Directorate General of Health Services. You also know that the ESP has five components, one of which is the Reproductive Health. The others are Child Health Care, Communicable Disease Control, Limited Curative Care and Behaviour Change Communication. The Reproductive Health component has been divided into two parts. One is vested in the Directorate of Family Planning (excluding neonatal care, obstetric care and STD/AIDS). These components are retained with the ESP of the Directorate General of Health Services. In the Directorate General of Health Services, the ESP has three additional components: Child Health Care, Communicable Disease Control and Limited Curative Care. In the Directorate of Family Planning, within the ESP, the Reproductive Health Care component has several sub-components, including Family Planning, Maternal Health, Adolescent Health Care, Unsafe Abortion Management, Infertility Care and other aspects of Maternal Health. Out of these, adolescent health is one of the most important issues, as it has not yet received due attention.

Though the family planning programme was launched in 1953 through voluntary effort, we have since marched forward, expanding family planning activities. As a result, CPR has reached an estimated 51 percent and the TFR has dropped to 3.2. Still, the programme has weaknesses, particularly in the field of sexually transmitted disease (STD), adolescent health and fertility control. So, the Health and Population Sector Programme has drawn into packages of all the components intended to improve the health of the women, children and poorest of the poor of this country.

Ladies and gentlemen, I have five Programme Managers with me. Dr. Rafiqus Sultan, the Programme Manager for the Maternal Nutrition and Adolescent Health sub-component, has informed me that he would like to do something in the field of adolescent health. I am also very grateful to ICDDR,B for accepting the offer to organize this type of workshop where we can take stock of what has been done from the government side and also from the private and NGO sectors. We deeply appreciate this type of cooperation and its contribution to the programme in its transitional stages for the selection of activities, development of action plans and identification of areas needing additional emphasis.

Ladies and gentlemen, with these few words I will close. We should use our time as it is apportioned so that we can finish our session by 1:30. Then we will have half an hour break for lunch and other activities. I similarly request all speakers to keep the time schedule.

In the closing session, Director General of Family Planning will address the workshop. Since he has some other engagements after his presentation, we will need to make sure that we stick to our intended schedule. Ladies and gentlemen, by the end of the day, we will know much more about adolescent health. What we hope is that when you leave this room, you will know more about the critical information concerning the adolescents of this country today. It is also hoped that you will feel more informed about the problems inherent to adolescent health education, fertility, early marriage, unmet needs for family planning methods, illiteracy, unemployment and severe poverty. You will also carry with you a bit of information about the activities, which are being attempted by the Government of Bangladesh. We believe that if we are open to suggestions for the improvement of our weaknesses with regard to adolescent health, we will be able to improve the overall development of Bangladesh in the near future. So, ladies and gentlemen, let us begin the business session. Thank you very much.

Working Session

An Overview on Adolescent Health Status and the Existing Adolescent Health Programmes

Dr. Rafiqus Sultan
Programme Manager
Maternal Nutrition and Adolescent Health
Directorate of Family Planning
and
Dr. Quamrun Nahar
Senior Operations Researcher, Operations Research Project, ICDDR,B

Introduction

Respected Chairperson, ladies and gentlemen, Assalamu Alaikum. Let us reflect upon the International Conference on Population and Development (ICPD) that took place in Cairo. There, it was pointed out that adolescents are a particularly vulnerable group. In the Action Plan of the ICPD, it was suggested that the government, in collaboration with non-government organizations, should aim to meet the special health needs of adolescents and establish an appropriate adolescent health programme. However, in Bangladesh, until now, very little effort has been directed toward adolescent health. In Bangladesh society, adolescents are generally considered to be healthy, since they have survived the illness of infancy and childhood. As a result, the health of adolescents has traditionally been given low priority. The health programme in Bangladesh is targeted primarily to children, women, and adults – not to adolescents.

Definition of Adolescents

Before discussing the health status of adolescents in Bangladesh, let us first know who are the adolescents. WHO has defined the term "adolescent" as the population segment aged 10 to 19 years with three specific characteristics. These are: (1) biological development from the onset of puberty to full sexual and reproductive maturity; (2) psychological development from the cognitive and emotional patterns of childhood to those of adulthood. (3) Along with these changes comes on emergence from the childhood state to total socioeconomic dependence to one of relative independence.

Global and Bangladesh Scenario of Adolescent Population

Let us take a look at the status of the adolescent population, the world population and Bangladesh's population. According to the WHO statistics of 1995, the world population is 5,881 million. The share of the adolescent population is 13.43 percent. Of this group, 51 percent are male and 49 percent are female. In Bangladesh's population, the same picture emerges. The total population in 1996, according to the Bangladesh Bureau of Statistics, is 122.9 million, where 24.70 percent are adolescents. Here, the adolescent proportion is much higher than it is in the world population scenario. However, the proportion of males to females is almost the same (51% and 49%) respectively.

Significance of Adolescent Population

Why is the adolescent period is so significant? One in every five persons on the earth, today, is an adolescent. Adolescents are, at the same time, the present and the future of the world, of nations and of countries. Adolescents are at increasing risk of unwanted pregnancies and contracting STDs, including HIV/AIDS.

Important Facts and Figures about Adolescents

Let us review some interesting and important facts and figures about adolescents. In Bangladesh, 50 percent of all 15-19-year-old females are married. The median age of first marriage in the case of women is 17.5 years. In the case of men, it is 25 years. The average age at first birth is 16 years. Over one fifth of all first births are to teenage mothers. So, teenage fertility is still very high. Thirty-one percent of teenage girls are mothers and another five percent are pregnant with their first child. Unmet need for contraception among married adolescent girls is higher than any other reproductive age groups. The contraceptive prevalence rate (CPR) among married adolescents is 31 percent, whereas the national figure is 51 percent. The mean interval between marriage and first birth is 13 months. High risk is associated with an early childbearing. The risks include maternal mortality and low birth weight. Half of the married adolescent girls aged 15 to 19 years are undernourished. The limited information that we have suggests that pre-marital sexual activity among adolescents is substantially higher among males than females and higher in urban areas than in rural areas. Information with regard to knowledge among adolescents about reproductive health is limited. Information about adolescents' knowledge and practices regarding personal hygiene is not available. However, unhygienic practices during menstruation are reportedly common. The health and family planning programme has traditionally been focused on married women and children.

Major Health Problems of Adolescents

Now, it needs to look more carefully at some of the health problems of adolescents in Bangladesh. These are nutritional deficiencies, early and unwanted pregnancies, menstrual problems, such as dysmenorrhoea, maternal morbidity related to early and unwanted pregnancy, complications of unsafe abortion due to unprotected and unwanted sexual activity, sexually transmitted diseases, addiction to tobacco, alcohol and certain narcotic drugs, accident, violence, and sexual abuses.

Adolescent Health Programme under HPSP

Now, let us review the adolescent programmes, especially the government programmes, in Bangladesh. Adolescent health is a new area in the health and population sector of Bangladesh. Only a minor segment of married adolescent girls receive maternal care or antenatal services. Unmarried adolescents rarely avail of opportunities to receive healthcare. Adequate progress in adolescent health education is yet to be achieved. As already announced by the chairperson in the inaugural session that the government has launched a five-year Health and Population Sector Programme, where adolescent health has been identified as one of the important components of reproductive healthcare. The government has given due emphasis on this. The plan for the first year of adolescent health activities is the development and wide circulation of behaviour change communication (BCC) messages to create awareness about the reproductive process, safer

sex, STD/HIV-AIDS, proper nutrition and hygiene, proper sibling care, adolescent contraception, and disadvantages of early marriage and pregnancy. Treatment of iron deficiency anaemia and treatment of certain gynaecological problems, such as dysmenorrhoea, will also be addressed. So, these are the intended activities to be implemented in the ESP under the HPSP.

NGO Adolescent Activities

At present, several NGOs are involved with adolescent programmes. In general, these organizations are of two types, i.e. NGOs that are providing funds and technical support to implement adolescent programmes, and NGOs that are directly implementing these programmes in the field.

Organizations, such as Voluntary Health Services Society (VHSS), Bangladesh Population and Health Consortium (BPHC), ACTION AID Bangladesh, Population Council, Save the Children-USA, and PLAN International, have been providing funds and technical support to other organizations to conduct adolescent programmes. With their funding and technical support, several other organizations have been directly implementing adolescent programmes at the field level.

Although the exact number of NGOs implementing adolescent programme is not available, it is clear from the VHSS AFLE Forum Member's list that more than 100 organizations have currently been conducting adolescent programmes throughout the country. Major organizations that have been working with adolescents -- targeting both girls and boys are listed (a list from the transparency) as Appendix 1.

Types of Adolescent Activities

If we look at adolescent activities, Adolescent Family Life Education (AFLE) is the main activity of most NGO programmes. Based on the information available, AFLE in Bangladesh was initiated in 1989 as part of the MCH-FP programme of some NGOs. Several other organizations, that have other programmes, like Non-formal Primary Education (e.g., BRAC) and the Family Development Programme (e.g. FDSR), have however, initiated AFLE as part of their larger agenda. Thus, the content of the AFLE programme varies depending upon the individual agenda of each organization.

Most organizations run AFLE activities at the community level. The CWFP and the BWHC have been holding sessions at the school level too. BRAC has also been running AFLE activities in its 210 non-formal schools and 21 government schools. Nari Maitree (NM) is planning to extend its programme to the school level. At the school level, special sessions are held in the classroom, and programme organizers conduct health education sessions. At the community level, sessions are held in groups, and groups meet several times each month.

Besides AFLE, some NGOs, such as NM, CWFP, and OMI, have established separate health clinics for adolescents. These clinics are open to non-member and to NGO member adolescents. Although qualified medical practitioners are available to provide primary healthcare services from these clinics, managers of these programmes have expressed concern about the low use of the facilities. To improve the coverage of adolescent health clinics, satellite clinics for adolescents have been arranged by the OMI. The NM targets adolescents by holding periodic health clinics at garment factories. The CWFP has been holding special clinic hours at its Chittagong project site. Besides AFLE and separate health clinics for adolescents, some NGOs offer supplementary programmes

for adolescents, such as income-generating activities (ash making, tailoring, and kitchen gardening), credit programmes, and skill development training. Some NGOs also provide legal support to adolescents. As most of these programmes target low-income families, it is believed that these supplementary programmes would help adolescent girls to be empowered.

Besides the programmes specifically run for adolescents, NGOs have also been organizing special programmes for teachers, parents, and the community leaders to make them aware of the adolescent issues. These are also to ensure community involvement in holding adolescent programmes. For instance, in BRAC programme, several orientation and discussion meetings with parents, teachers and the community leaders are being held to elicit ideas and opinions on how to improve programme activities.

Strengths and Weaknesses of the Activities

During the last decade or more, although a number of activities are aimed at addressing reproductive health and other needs of adolescents in the Bangladeshi context, these activities were of relatively small-scale, were pilot efforts, have primarily focused on adolescent girls, and are poorly documented and evaluated. In fact, only a few organizations, made comprehensive documentation.

In spite of the above-mentioned limitations of adolescent initiatives, the success made by these small-scale projects should not be overlooked. Success of these projects cannot be measured in terms of impact due to inherent difficulties in programme planning and documentation. But effectiveness could be partly judged by the level of community mobilization these programmes have initiated. From the onset of the programme, AFLE has drawn remarkable appreciation from the community, as well as the donors. It has also generated enthusiasm among its adolescent participants. Although scant formal evaluation has been done for this programme, it seems that adolescents have benefited from it. One evaluation, done by the BPHC in its three projects, found that girls trained in AFLE were more knowledgeable and more vocal about MCH-FP and gender issues than girls not trained in AFLE. They particularly expressed strong views against dowry and polygamy.

Besides the impact and effectiveness of the NGO adolescent programmes, there are other accomplishments that could be regarded as milestones in addressing adolescent health issues in Bangladesh. These include: holding of meetings; formation of adolescent forums; development of AFLE curriculum and IEC materials; and development of training curricula for adolescents.

In August 1991, a seminar was organized by the VHSS to bring together different organizations interested in adolescent issues. An AFLE Forum coordinated by the VHSS was also formed in 1991. Besides this forum, there are currently five other adolescent forums, such as DAWN Forum, BPHC Forum, ACTIONAID Forum, USC-Canada Forum, and CMES Forum.

A curriculum and IEC materials developed by the VHSS are being used by most organizations. Some organizations have, however, developed their own AFLE curricula based on the VHSS curriculum. Although NGOs, such as BRAC, VHSS, and CWFP, have given training of trainers (TOT) to several NGO workers, these trainers are still in need of greater skill development. An evaluation done by the BPHC, in its three funded projects, documented that the training method used for the AFLE programme is lecture-oriented. Thus, the training method allows very little scope for adolescents to discuss their feelings or ask questions during the sessions.

The Future Needs

A major information gap exists with regard to reproductive health knowledge, attitudes and practices among the adolescents in Bangladesh. This is especially true for the unmarried adolescents. Thus, there is an urgent need to identify and address the reproductive health needs of adolescents. In this regard, qualitative and quantitative studies should be planned for both adolescent boys and girls.

Since most existing adolescent programmes are targeted to girls, more programmes should target adolescent boys with information and services relevant to their needs.

Although a number of organizations have initiated adolescent programmes in Bangladesh, most of these efforts are of relatively small-scale as already mentioned elsewhere in this document. There is currently a lack of understanding about how programmes can expand their coverage, or how to implement strategies that reach large numbers of adolescents, such as mass media campaigns and social marketing. Therefore, there is a need to document and evaluate the existing adolescent programmes, so that lessons learned from these projects can be used for scaling-up successful interventions.

As in other developing countries, access to, demand for, and use of health services among adolescents seem to be very limited in Bangladesh. Moreover, the existing healthcare system is not designed to fulfill the needs of unmarried adolescents. Healthcare providers are neither aware of the special health needs of adolescents nor are they prepared to provide reproductive health services to adolescents. Thus, the healthcare system needs to be upgraded to address adolescent health needs. Protocols, guidelines, and standards of how providers should serve adolescents should be spelled out clearly.

Since adolescents are a part of the community, and many of the adolescent issues are rooted in the sociocultural norms of the society, efforts need to be made to involve community groups, such as parents, teachers, and guardians, in adolescent programmes

There is a pressing need to conduct operations research in designing, implementing and evaluating adolescent programmes. Programme staff should help determine what aspects of their programmatic strategies should be tested through operations research.

Finally, research should be conducted to design and define appropriate indicators to evaluate the progress of adolescent interventions. To develop indicators, the conceptual framework for the adolescent strategies in Bangladesh should be documented.

ORP's Current Plan about Adolescent Health

The ORP is planning to undertake two major activities with regard to adolescents. First, it plans to conduct a detailed assessment of the reproductive health needs of adolescents in the context of Bangladesh. This will start at the end November, 1998. Needs assessment will be conducted by applying both qualitative and quantitative data collection techniques. Second, depending on the findings of needs assessment, ORP will work with other NIPHP partners to design strategies to address the reproductive health needs of adolescents.

(Relevant slides of this presentation are attached as Appendix 1).

Government School Health Pilot Project

Dr. Khaled Shamsul Islam
Ex-Deputy Project Director
School Health Pilot Project, Directorate General of Health Services

Background

Respectable Chairperson and distinguished participants. Before giving you a brief detail of the School Health Pilot Project, I would like to offer a bit of background for the effort. In 1948, a school health clinic was first initiated. Up to 1972, a total of 25 school health clinics were established with assistance from UNICEF. Of these, three were in Dhaka City and three in Chittagong. The remaining 19 school health clinics were located mainly in the old greater district headquarters, including former three sub-divisions - Patuakhali, Jamalpur and Bandarban. After 1993, a master plan was developed with the help of research partners. According to the master plan, a pilot project, titled School Health Pilot Project, a project of the Directorate General of Health Services (DGHS), was launched in 1996.

Objectives

The objectives of the pilot project were mainly to: I) provide health education as part of the regular curriculum of school children, along with basic health promotion, disease prevention and health screening services; 2) provide first-aid services and refer critical cases to providers; and 3) provide a safe and healthy learning environment (i.e. provision of safe water, adequate sanitation, lighting and ventilation) as part of an atmosphere conducive to learning, through cooperation and coordination with other government bodies.

Project Description

The School Health Pilot Project is funded by the GoB and the Swedish SIDA. The project sites are in 39 thanas of the four selected districts. Eight thousand schools from the 39 thanas are listed for participation in the programme. This figure includes all government and non-government primary and secondary-level schools and madrashas from the 39 thanas. These schools and madrashas were listed with the help of the Directorate of Primary Education, Directorate of Secondary and Higher Education and the Madrasha Board. With the help of these agencies the project listed the names of the teachers who are primarily responsible for carrying out the school-based health programme. Thus, the selected teachers are the focal points of this project. Two main categories of teachers were selected for the programme: (1) physical education teacher and (2) biology teacher (or teacher with other science background). The target group of the programme is school-going children, particularly from class five to ten. Thus, the total target group is estimated at around 2.2 million school-going children attending the 8,000 schools from the 39 thanas of four pilot districts.

The project has three main components, namely 1) school health services which include limited curative care services, first-aid, deworming, immunization and micronutrient supplementation; 2) school environment which ensures safe water supply

and adequate sanitation, light and ventilation; and, 3) health education which includes two strategies: (a) developing curriculum with the help of National Curriculum and Text-book Board (NCTB) for a health education training programme and incorporation of the test, specially for students of classes five through ten; and (b) providing training to the teachers and health personnel who are responsible for imparting training to the school students.

To meet the training needs of health education programme, we have three master trainers, who have undertaken both national and international training. The master trainers provide TOT to 161 participants from the four selected districts. They include District Education Officer, District Primary Education Officer, and District Health Education Officers. The Civil Surgeon, Deputy Civil Surgeons, Principal of Teachers' Training College and Superintendent of Primary Training Institute also attended the TOT. This is expected to familiarise them with the programme so that they could adequately supervise and monitor it.

One teacher from each of 8,000 schools was selected to undergo the training to be imparted by the 161 trainers. In the thana, the project constituted a thana training team comprising of three members, namely Thana Health and Family Planning Officer, Thana Education Officer or Assistant Thana Education Officer and Medical Officer-Disease Control. This is the core team designated for overall management of the training programme at the thana level. The topics of the health education-training programme include personal hygiene and cleanliness, safe water and sanitation, food and nutrition, first-aid, common ailments, referral system, population education, and STD and HIV/AIDS. The last two are especially important to the adolescent programmes of the country. As one of the training activities, we also have a programme for the training of field staff. We have not, however, been able to complete the training of the field staff within our stipulated timeframe.

Current Status

The curriculum has been developed, and some of the components have been incorporated into the textbooks. Curriculum development and incorporation has been largely undertaken by our WHO consultants, Ms La Rue K Seims and Professor Kafiluddin Chowdhury. As of today, we have completed the training of our master trainers and 161 trainers, and teacher's training has been partially completed. Distribution of first-aid boxes at the 8,000 schools has also been carried out. Health cards and referral forms have been distributed to all schools. Ten types of IEC materials have been developed and distributed to the schools. The project has been incorporated into HPSP as a component of Child Health under ESP. Thank you all.

(Copies of the relevant slides to this presentation are attached as Appendix 2).

Adolescent Family Life Education of BRAC/HPD

Dr. Shamsher Ali Khan
Sector Specialist
Health and Population Division, BRAC

Background

Adolescent is a period of transition between childhood and adulthood in which the body develops in size, strength and reproductive capacity. These are the formative years when the maximum amount of physical, psychological and behavioural changes takes place. It is a time when the size and shape of the body change markedly, and the differences between boys and girls are accentuated.

WHO has defined adolescent as the aged between 10 and 19 years. Today, there are more than one billion young men and women aged between of 10 and 19 years in the world - the largest generation of youth in history (The Alan Guttmacher Institute, May 1998). Although young people comprise a large percentage of the world's population, their health has largely been ignored. The reason behind this is that they are considered a "healthy" age group by policy-makers. Young age is a risk factor for maternal mortality. One study in Bangladesh found that girls aged 10 and 14 years had a maternal mortality ratio five times higher than that of women aged between 20 and 24 years (Chen, 1994). Even with this high mortality related to young pregnancies, these women are rarely given special care, assistance or emotional support (UNICEF, 1994).

Although adolescents are at risk of STDs, they are generally uninformed on the issues. Young women have higher biological susceptibility of STDs due to the immaturity and vulnerability of the reproductive mucosa. Significant risk of cervical cancer was found among women reporting first intercourse at the age of 14 and 15 years (Herrero, 1986). One study done among secondary school students in Cameroon reported that fewer than 20 percent of the respondents could give accurate information about any STD or its prevention (Mafny, 1990). The Bangladesh Population Council study supports these findings, with data to suggest very poor knowledge about reproductive organs and symptoms of STD among adolescents.

Adolescent sexuality is a difficult subject to breach by either parents or adults. Adolescents suffer from lack of information and understanding about their own sexuality. Boys suffer from peer pressure to indulge in early sexual activities, smoking and drug abuse to prove that they are men. Adolescents are the parents of the next generation. They should, therefore, be given every opportunity to develop their full potential as healthy individuals. Teaching of adolescent reproductive health issues will help ensure this by improving their levels of knowledge, their attitudes and their practices with regard to reproductive health.

Overview of Bangladesh

As in other developing countries, the period of adolescence is not well recognized in Bangladesh. In Bangladesh, it is a breach of cultural norms to discuss about sexual matters prior to marriage. Thus, needs and problems faced by adolescents are largely unexplored and ignored.

Adolescents (10-19 years) make up about 23 percent (29 million) of the total population of Bangladesh. In terms of their sheer number and their demographic impact, adolescents deserve special attention. Half of the 15-19-year old females are married. Typically, these girls become pregnant soon after the marriage. Only one-third of the married adolescent girls practise contraception. Nevertheless, unmet need for contraception among married adolescent girls is higher than for any other reproductive age group. Early childbearing not only causes high morbidity and mortality, but also hinders the educational and social development of these adolescent girls.

In view of the above, BRAC developed and introduced an adolescent family life education programme (AFLE) for adolescents both in school (secondary school, non-formal primary education school) and out of school system (*Kishoree Pathagar*) as a pilot programme in January 1997. BRAC establishes informal schools that provide three years of primary schooling to adolescents who have never attended school. Monthly AFLE sessions are integrated into the secondary school curriculum among adolescents aged 10-16 years.

Objectives

The overall goal of this pilot project is to improve the reproductive health status of adolescents. However, the specific objectives are:

1. To increase the awareness of adolescents with respect to reproductive health issues (thereby ensuring healthy reproductive development).
2. To develop an effective reproductive health curriculum for both formal and non-formal educational settings.
3. To study the effect of reproductive health education on the knowledge and attitudes of adolescents.
4. To examine the responses of family members and teachers to the reproductive health curriculum.

Activities

- Developed two sets of curriculum for Non-formal Primary Education (NFPE) and secondary schools. The age range of students attending NFPE schools is 9-12 years. Those who attending secondary schools are aged 13-16 years.
- Implemented the Adolescent Family Life Education (AFLE) programme in 21 areas of Reproductive Health and Disease Control (RHDC) among Grade 1 students.
- Held a workshop with teachers, including the headmasters, in all selected schools to encourage support for the programme, build consensus and ultimately develop a formal agreement of permission using a letter of understanding.
- Provided orientation to 84 programme organizers (POs), both male and female, who teach AFLE to students.

- Collected baseline data (with a questionnaire) to assess knowledge, among adolescents, about reproductive health.
- A monthly reporting system has been developed using a reporting format.

AFLE Methodology

- BRAC programme organizers (POs) – both male and female – organize one AFLE session per month per year.
- In secondary school, the curriculum spans a seven-month period (one session each month on a particular topic).
- Secondary schools and *Kishore Pathagars* are selected based on the number of students/members and accessibility.
- Meetings with parents, teachers and community leaders are held to solicit ideas and opinions on how to improve the programme effectiveness.
- A mid-course workshop with school teachers is held to share their experiences and concerns, and solicit feedback.
- A network of government and community members has been developed. Here participants have the opportunity to share their advice and suggestions.
- School teachers are observed during the session and refresher training is given, if needed.

Scale of AFLE Programme

1. Secondary School

- 21 schools (1,553 students)
- 6 girls' and 15 co-education schools
- Age range: 13-16 years, Grade -6

2. NFPE School

- 202 schools (6,666 students)
- Age range: 9-12 years

3. Kishoree Pathagar

- 210 pathagars (7,102 members)
- Age range: 10-19 years

Issues Discussed in NFPE School

Basic health hygiene and nutrition:	-	Personal hygiene
	-	Environment
	-	Water and sanitation
	-	Helminthiasis and goitre
	-	Infectious disease
	-	Food and nutrition
Reproductive health issues:	-	Reproductive health and menstruation
	-	Marriage and pregnancy
	-	RTI/STD
	-	Family planning

Issues Discussed in Secondary School

- Food and nutrition of adolescents
- EPI and growth monitoring
- Helminthiasis and goitre
- RH and menstruation
- Marriage and pregnancy
- RTI/STD
- Family planning

Programme Strategy

The programme organizers (POs) attend classes for one hour each month. The programme organizers are given a one-day orientation on adolescent health. These trainers previously received general TOT and have experiences as trainers. The trained POs are monitored by the Area Manager through a structured checklist. The head office staff also monitors the programme. In addition, a quality control team supervises the programme using a quality clarification checklist. A monthly report is sent to the MIS unit.

Future Plan

During the period of July-September 1998, a series of focus group discussions (FGDs) was conducted to assess the knowledge of the target group and applicability of the curriculum in terms of information needs. Curriculum was subsequently revised to reflect the findings of the FGD.

Revisions are currently being made on those topics selected by the students. In this respect, discussions were held with the students and teachers of the school to determine which particular health issues required further clarification or revision. It was decided that school teachers would conduct revision classes, in which students could receive more in-depth information about those topics which demand further emphasis.

The programme will be replicated in all RHDC areas. All secondary schools (14 per area on an average), NFPE schools and *Kishoree Pathagar* will be included in the programme. The programme will cover all secondary schools (contingent upon permission), KK school and *Kishoree Pathagar*. The target groups in the secondary school will be students of Grade 8 and 9. In formal schools, students aged 13-19 years will be targeted. One male and one female teacher from each secondary school will be selected and be given training on reproductive health education.

Future Needs of the Programme

Programme planners have identified the following needs of the programme:

1. According to an assessment of the reproductive health curriculum, adolescents thought that the curriculum should focus more on reproductive health and sex education than family life; that drug abuse issues should be discussed; and that the use of contraceptive methods should be demonstrated. The assessment also concluded that programme-wide peer networks should be strengthened; that teachers need more support to teach the curricula in ways that it is appropriate for adolescents (i.e. interactive teaching methods, such as role-play and drama).

2. Understanding and documenting the dynamics of community involvement and the shifts from community resistance to social action are needed. Documentation of how BRAC is able to communicate about sensitive issues would facilitate programme replication and foster social action.

3. BRAC has anecdotal evidence that people exposed to one aspect of the programme become agents of change, and that involvement or exposure to several interventions may expedite the change in social norms. Developing indicators to capture this "snowball" effect would help track the programme's evolution as new innovations are added.

Achievements

1997

* During the past year, 147 sessions (100% of planned sessions) were held in secondary schools covering 7,123 students (66 percent of the intended target).

* Two thousand three hundred and thirty sessions (78 percent of the planned AFLE sessions) were held in *Kishoree Pathagars*. A total of 37,828 members (52 percent of the target) attended the sessions.

* Two thousand one hundred and sixty-four AFLE sessions (88 percent of the target) were held in the NFPE schools, and 63,778 students (90 percent of the target) attended the sessions.

1998 (January - June)	*	Thirty-eight AFLE sessions were held in secondary schools, and 52 percent of the expected students attended the session.
	*	Of the 528 expected AFLE sessions, 384 were held in the *Kishoree Pathagar* (72 percent of the target). A total of 6,260 students attended these sessions (51 percent of the target).
	*	Three hundred and eight AFLE sessions (80%) were held in the NFPE schools, and 9,271 students (85% of the target) attended the sessions.
Training	*	Thirty-six secondary school teachers were trained on AFLE issues, and 25 teachers were present as observer participants in the revision classes.

Adolescent Health and Development Programme of Nari Maitree

Ms. Shahin Akhter Dolly
Executive Director
Nari Maitree

Distinguished Chairperson, ladies and gentlemen, Assalamu Alaikum. First, I would like to thank ICDDR,B for giving me the opportunity to share with you our adolescent health programme. Before sharing our programme, I would like to say a few words about our organization. Nari Maitree is a women's development organization. It was established in 1983. Our organisational goal is to empower unskilled women of the society and to ensure their socioeconomic development. We also work toward the achievement of organizational sustainability. To achieve this goal, we have undertaken assorted activities, such as an MCH-FP programme, an education programme for working children, an HIV prevention programme, an income-generation programme, a women's rights programme and a programme for adolescent girls. Here, I would like to highlight the adolescent girl programme, which is being funded by ACTION AID. When we started this programme, it was funded by BPHC as a component of our MCH-FP programme. The adolescent girl programme, currently being funded by ACTION AID, began back in 1996 in Ward 27 of Dhaka City Corporation.

Goal

The overall goal of the programme is to prepare adolescents for adult realities, parenthood and leadership while establishing their position in the family and society as a whole.

Objectives

The objectives of the programme are:

- To launch a mass awareness-raising campaign on the concept and significance of adolescence
- To provide reproductive services
- To raise awareness about the negative effects of an early marriage on adolescent pregnancy
- To inform adolescents about their legal rights
- To encourage adolescents to get involved in the decision-making processes of the family
- To encourage adolescents to get involved in income-generating activities
- To introduce and promote non-traditional activities.

Activities

Now, I would like to discuss the different activities of the adolescent girl programme. The activities are as follows:

- Conduct a baseline survey for the selection of adolescents
- Impart education to adolescents about family life
- Provide counselling for adolescents about health issues
- Provide reproductive healthcare services through clinics
- Develop referral services to ensure appropriate treatment
- Identify and create groups
- Conduct group awareness training
- Mobilize legal support
- Provide skills training
- Distribute credit
- Provide training on non-traditional activities
- Create awareness about adolescents among guardians and community members
- Advocate registered marriage and prevent early marriage.

To perform the above activities, we followed a step-by-step process. To select the adolescent girls for the programme – thereby forming a group – we first assessed the needs of each adolescent girl through the use of a baseline survey. Ultimately, we formed groups each consisting of 10-15 girls. As soon as a group was formed, the group members selected the group leader. The leader then arranged a weekly group meeting. In the meeting they discuss a variety of issues, including savings, credit, local situations and personal problems.

To increase the knowledge level of the adolescent groups we provide family life education (FLE), following the curriculum developed by the Voluntary Health Services Society (VHSS). The FLE classes are conducted for two hours by our organizers in the field. Also, we have set up a clinic with a trained doctor, a counsellor and a health educator to provide reproductive healthcare services. The clinic provides various services, such as antenatal care, postnatal care, immunization, general and STD/RTI treatment. In the clinic, the adolescents are provided with counselling on the changes that take place in the body during adolescence. They are also introduced to a wide variety of reproductive health issues. To support these service facilities we have included a Satellite Clinic in our field operational area.

With regard to skill development among adolescent girls, we have arranged different types of skills development training, including leadership building, group management, human development, sewing and embroidery. Recently, we have included training on non-traditional activities, like food processing, auto rickshaw-mishuk driving. After skill development training is complete, we provide credit to the participants as per their choice of profession. The participants can then invest their loans in income-generating activities to help them earn money. We believe that although they invariably share their earnings with the family, the earning potential helps them establish their voice within the family.

The community-awareness activity is meant to sensitize the community (especially the parents), so that they begin to see adolescent issues and problems as worthy of serious consideration. We conduct this activity through discussion and dialogue in a number of different forums. These activities we consider as programme input. As programme output, we have 26 adolescent girls' groups. Of these girls, 98 have received loans from our credit programme. By and large, feedback from the community toward the programme is positive.

Problems Faced over the Last Couple of Years

Following are the problems we faced in implementing our programme:

- During the baseline survey, most parents did not provide proper information.
- Some parents forbade us from talking about family planning, the life cycle, HIV/AIDS, and STDs to their adolescent girls.
- Members of the community were reluctant to cooperate.
- Most parents did not allow their adolescent children to come to the clinic.
- Parents did not allow their adolescent children to get involved in non-traditional activities.

Success

Despite the long list of problems and difficulties, we have accomplished a moderate number of successes throughout the programme period. These are highlighted below:

- Adolescent girls, who participated in the programme (graduates), became aware of their health and reproductive rights as well as their human rights.
- Graduates now talk about health and other issues openly and freely with doctors, organizers and even their mothers.
- Graduates have developed a sense of responsibility.
- Graduates are now taking risks by getting involved in non-traditional activities.
- Seventy-five percent of the girls were married at an appropriate age (as per law) after our involvement with them.

Lessons Learned

To summarize the discussion, I shall now present a list of lessons that we have learned over the study period.

- We have been working only with girls. Our experience, however, suggests great potential in working with boys as well.
- There is a tremendous need for this programme, since adolescents are so shattered from information related to their essential physical, mental, emotional and social development.
- Community participation is the key to success in this type of programme.

The Future Plans

Following is a list of future plans for the programme:

- Continue training on non-traditional trade activities
- Expand the programme based on need
- Provide services for both girls and boys
- Distribute loans to groups
- Undertake gender-awareness activities with newly-married couples.

Rural Adolescent Boys' Programme of Family Development Services and Research

Fatema Alauddin, Ph.D.
Chairperson
Family Development Services Research

Our organization, Family Development Services and Research, in short FDSR, has a long experience of about 11 years in the field with programmes aimed at creating awareness among rural adolescent boys about growth, health, hygiene, nutrition, environment, self-employment and related issues. I would now like to present a short overview of the programme and its activities under the following broad headings:

1. When did FDSR start its boys programme
2. Why did FDSR start the programme in rural areas of Bangladesh
3. Where did it start the programme
4. Through whom was the programme launched
5. Programme implementation
6. Programme activity
7. Problems encountered
8. Lessons learned from the programme
9. Future plans for FDSR

I would now like to touch upon the points serially.

When Did FSDR Start its Boys Programme

We started the programme in 1987, although preparatory work was initiated during the preceding year.

Why Did FDSR Start the Programme in Rural Areas of Bangladesh

The normal work area of the FDSR is rural Bangladesh. We are aware of the problems engendered by traditional male dominance in rural societies. It has been observed that education is a prerequisite to positive changes in lifestyle; without it, an individual cannot recognize or appreciate the need for change. FDSR noticed that boys aged between13 and 19 years are the most receptive to informal learning. Thus, they should be tapped. It was observed that the boys were eager to overtake the girls in family life education which was already being imported to adolescent girls under FDSR's AFLE programme, and the girls were becoming more informed. Thus, competitive attitude among the boys triggered a valuable incentive. FDSR studied the whole situation and eventually embarked on the project in rural areas.

Where Did it Start the Programme

We first started the adolescent boys programme in 38 unions under four thanas in Bangladesh. The thanas are: Gopalpur in Tangail district. Raipura in Narsingdi district, Singra in Natore district, and Godagari in Rajshahi district. The scheme was later extended to another 16 unions of three thanas: Satkania and Banshkhali in Chittagong district, and Teknaf in Cox's Bazar district.

Through Whom was the Programme Launched

We did not put any extra burden on our establishment cost. The supervisors and workers of the FDSR's integrated MCH and FP programme started the new programme through a voluntary initiative. This was possible because the work was done preliminary part-time and on selected weekdays. The top-level manager, mid-level managers and line staff (both clinical and non-clinical) of the aforesaid integrated programme took up the overall responsibility of executing the boys programme.

Programme Implementation

The mid-level managers prepared the criteria for selecting boys and determining the number of participants, course duration, syllabus, etc. The supervisors prepared the lists of boys who showed interest in the programme. Then they met the boys personally and informed their parents of the details of the programme, course contents, course duration, and expected impact of the course on the life of their sons and other members of the family. Parents' signatures were obtained on a printed consent form.

The course inauguration was done ceremonially in the local project office. The selected boys, their parents/guardians, local elite and community leaders were invited to attend the function. The FDSR officials and local leaders congratulated the parents/guardians who allowed their sons to join the programme, encouraged the boys and thanked the project staff for accepting the extra responsibility without compensation.

The supervisors began the AFLE courses in their own homes or in places where the boys felt free to participate. Before starting this phase, however, the selected supervisors were trained by the top- and mid-level managers of the FDSR's MCH and FP Programme on how to run an AFLE course for boys. Each supervisor was responsible for providing AFLE to 8-10 adolescent boys in his respective service area.

To add further impetus to the programme, FDSR started an additional scheme for providing loans to those adolescent boys upon completion of the course. These loans were offered for income-generating activities, such as cattle raising and poultry farming. The move was widely appreciated.

Since the MCH and FP project of FDSR ended in August 1997, the Adolescent Boys Programme had to be redesigned to keep it operational even after the original operators were gone. The programme has now been hooked up with the FDSR's new Family Health Services project at seven project sites. A part-time Programme Assistant is assigned to provide AFLE to the boys at each site, while a Programme Officer stationed in the FDSR head office monitors the progress.

The course duration is 12 months. Boys attend the project office four days a month (each Thursday). They spend one of these days in AFLE session and the other three days in playing indoor games and reading books of their choice. They spend 2/3 hours at the project office after school hours.

Programme Activity

The adolescent Boys Programme opens avenues for activities appealing to the growing boys. These may be broadly classified as:

- Providing family life education by following comprehensive curricula specially designed for the programme. A copy of the topics of the curricula is enclosed.
- Providing indoor games and space for recreation. Games attract the boys to disciplined engagements away from aimless loitering, scuffling, etc.
- Providing a setting conducive to reading and constructive reading materials for the boys. Plenty of high-quality books, magazines, and newspapers are available at the centres. This helps them develop reading habits and unprejudiced thinking faculty.

Problems Encountered

In the absence of support, the programme is being carried out under extreme financial constraints. It is difficult to procure the training materials, new books, magazines, indoor games and furniture essential to such a programme. Despite his negligible remuneration, the Programme Assistant has to work very hard. And although there is a very big demand for outdoor games, nothing can be done due to lack of funds.

Lessons Learned from the Programme

The adolescent programme, by virtue of its specialized nature and wide expansion prospects, needs to be implemented as a single and exclusive project. It should not be linked or combined with any other projects, since such cooperative efforts tend to suppress the performance and results of the smaller associate.

A participatory approach would be advisable for the preparation and implementation of such a programme. Participants need to be given opportunities to assist the project personnel in policy formulation and the implementation process. There will be a spontaneous and effective response if the programme is structured in accordance with the wishes of the participants.

The support and cooperation of the local community is of prime importance. There should be a strong drive for confidence building in the field.

Future Plan of FDSR

Raising funds to strengthen the existing programme will be a priority issue. The programme will be expanded to other project sites. Prospective sites are under consideration.

Following are the topics of the curricula used for FDSR's programme

Adolescent Family Life Education (AFLE) Curricula

1. Necessity of education for improving the quality of life
2. Physical and mental changes that occur during adolescence.
3. Ways of keeping body and mind healthy and positive during adolescence.
4. Selection of friends.
5. Criminal behaviour among the Bangladeshi adolescent boys/girls.
6. A few social customs which are harmful for adolescents.
7. A few habits which are detrimental for adolescent boys/girls. Extent of sexually transmitted diseases among adolescent boys/girls in the country.
8. Social activities in which adolescent boys/girls are now involved in.
9. Kinds of occupation in which adolescent boys/girls are new involved.
10. Government and non-government organizational efforts to improve the quality of life for adolescent boys/girls in the country.
11. Barriers to improving the quality of life among adolescent boys/girls.
12. A few ways to improve the financial conditions of adolescent boys and girls.

Adolescent Empowerment Programme of Concerned Women for Family Planning

Ms. Mubarra Matin
MIS Offier
Concerned Women for Family Planing

Background

Concerned Women for Family Planning (CWFP) is a non-profit national-level voluntary organization of women in Bangladesh. The mission of the organization is "To support, promote and protect the interest of the women of Bangladesh by empowering them to achieve a better status." From its inception in October 1975, it has been the CWFP's mission to work for the improvement of women's lives by offering family planning and maternal and child healthcare, training, skill development, savings and credit. CWFP started its work by distributing contraceptives in the slums of Dhaka city and by providing information and education on family planning to the doorsteps of women.

The service-delivery model has shifted from a community-based distribution approach to an approach using the primarily static and satellite clinics as the delivery sites. Under this programme, which is referred to as the National Integrated Population and Health Programme (NIPHP), CWFP provides services in two urban clusters of Bangladesh - Dhaka and Mymensingh.

After 20 years of working for the eligible couples of Bangladesh, CWFP felt the need to shift a portion of their energies to the adolescent girls who represent the mothers of the country's future. If these girls are made aware of their educational needs, their health needs, their legal and social rights from the beginning, they will be able to apply them in their own life and have some influence over their families. The adolescent project of CWFP came into being to address these issues.

Objectives

1. To provide adolescent girls with elementary, essential and practical knowledge on reproductive health, including population issues, pregnancy, childbirth and basic physiology, nutrition, personal hygiene and family life.
2. To provide adolescent girls with essential legal rights education to inform them of their position and rights in the society within the religious and legal framework.
3. To provide healthcare services to adolescent girls.
4. To provide groups of adolescent girls with various trade skills.
5. To motivate adolescent girls to develop savings and to avail credit.

Population Served

1. Both married and unmarried girls who are in the 9-19-year age group.
2. Adolescent girls are divided into the following groups:

a) School-going girls aged over12 years

b) Out-of-school girls aged 9-19 years (broken down into two groups: 9-13 and 14-19).

Activities

These adolescent girls reside in CWFP's working area; CWFP has been providing services to their mothers and has seen them from birth. Over the years, CWFP has acquired the community's trust and respect. Nevertheless, the workers still organized community meetings with the parents, explaining the programme to them, emphasizing its advantages and requesting them to allow their daughters to attend.

1. Formation of groups

- 6 groups per selected area
- 5 from the community; 1 from a school
- 20-25 (approx.) girls per group
- In Dhaka: 18 groups
- In Chittagong: 36 groups
- In Tangail: 12 groups

Total number of girls: 1,492

2. Non-formal education

- Person responsible for conducting classes
  - ➢ Counsellor-cum-educator: TOT recipient;
  - ➢ Peer educator: leadership training recipient (in absence of counsellor, takes charge of class).
- Teaching methods
  - ➢ Curriculum, visual aids, lectures, participatory discussions
- Frequency
  - ➢ Community: two sessions per week
  - ➢ School: one session per week
- Topics
  - ➢ For the 9-13-year age group: family life, personal hygiene, nutrition, menstruation, and human rights
  - ➢ For the 14-19-year age group: in addition to the above, pregnancy and childbirth, legal rights and population issues

3. Healthcare services

- Complete course of tetanus toxoid (TT) immunization
- Ensure accessibility to organizational health centres

4. **Trade skill training**
   - Recipients: out-of-school girls
   - Skills: sewing, handicrafts

5. **Savings and credit**
   - Savings: each member deposits five taka per week
   - Credit: a member can obtain credit to start a small business

Achievements

The adolescent programme was built on the underlying assumptions that:

- informed, skilled youths can be motivated to make healthy choices and to ultimately create an environment that facilitates these choices
- through promotion of healthcare, prevention of health problems is possible
- employment opportunities will lead to dramatically improved conditions for adolescents

In this programme, 1,492 adolescent girls were provided with non-formal education and given TT immunization. In the CWFP adolescent project area, CWFP was able to refer the girls to its own health clinics.

In the credit project, 292 girls were provided with credit to start a small business, such as raising poultry, rearing livestock. With the earnings from their business, they can pay back the loans, and can also use those earnings for education or health purposes. Addressing poverty by providing economic opportunities helps eliminate the disadvantaged conditions within the family.

Rupa (not her real name) was married at the age of 14 years. Until her marriage, Rupa was attending school. Due to the restrictions imposed by her in-laws, her education was discontinued. Rupa was also a member of CWFP's adolescent programme before her marriage. Though she got married at a very early age, she is still able to apply what she learned from the programme to her life. She is currently using contraceptives to postpone her first pregnancy. Her parents and husband are in support of this since they are aware of the risks of an early pregnancy.

A mother involved in the programme delayed her daughter's marriage after seeing, first-hand, the disadvantages of an early marriage (her elder daughter had been married at a young age). This information, along with the education her daughter received in CWFP's programme, was responsible for the decision to delay the second daughter's marriage. With the help of the project's credit programme, her daughter helped support her family in buying a piece of land.

Barriers to Achieving Positive Outcomes

Rupa, mentioned earlier, has been able to make a choice regarding pregnancy. On the other hand, she could not prevent her early marriage. This is how her parents explain the situation: "it is very difficult to arrange a marriage for a girl; dowry and age act as

relative factors and a suitable bridegroom is not always available. This is why a poor father must overlook all of the disadvantages and send his young daughter to her in-law's house." There are many cases like Rupa's. But few of them are as fortunate as Rupa in being able to use contraceptives to prevent an early pregnancy because of the pressure from their in-laws' to bear children soon after marriage.

Among girls, there is a preference toward delaying marriage, because they understand that marriage signals the end of freedom of being an individual. They also know, at some level, the hazardous effects of childbearing on their health. And finally, there is a belief that reproductive health is a taboo subject. Therefore, girls are hesitant to seek healthcare regarding reproductive health problems.

Parents prefer that their daughters are married before they attain puberty. The reasons behind this are: i) lack of security for girls, ii) the perceived ease with which a young mind can be moulded into the desired shape, and iii) poverty. Another important reason behind this is the lack of information; parents are not aware of the disadvantages of an early marriage.

Actions Taken and Future Plan

- An adolescent-specific clinic with a female doctor was recently established in Chittagong.
- The health services, non-formal education, skills training and savings and credit programmes are all offered from the same building.
- Boys, parents and in-laws will be included in the non-formal education programme.
- Peer educators will be developed to serve as an outreach link to the community.
- A youth club will be established; members will hold special programmes, including rallies and cultural functions on special health days.

Expected Outcomes

- Increased use of healthcare centres
- Development of an integrated approach that will increase accessibility to all available services, especially health care.
- By including boys, the girls' future partners are being simultaneously developed.
- Parents and in-laws will be able to make the appropriate choices with regard to health.

Peer educators will give credibility to the programme. Such involvement also enhances the leadership potential of the young people who have been trained as peer educators.

Presentations by Two Adolescents

Ratna, Group Member, CWFP's Adolescent Programme
Saiful Islam, Group Member, FDSR's Adolescent Programme

Ratna: Assalam Alaikum. I would like to say that since the programme is for adolescent girls, it would have been better if the speech could have been delivered in Bangla. Unfortunately, we could not understand many things. Nevertheless, let me tell you about my experience with the CWFP's adolescent programme. I was involved from the very beginning of the CWFP's adolescent programme that started in mid-1997. The *apas* (sisters) of CWFP initially went to different places to organize groups of adolescent girls. Then they sat with us for discussion. Being adolescents, we had many issues and questions that we wanted answers to. We could not share these issues with other adults due to shyness and fear. The CWFP sisters, however, encouraged us. Therefore, we were able to express our feelings to them. In this way, we were able to get answers for many of our queries. We have learned about the physical and mental changes that occur at this age. The issues, which the CWFP *apas* told us, were not covered either in our school or in college.

The other merit of CWFP's programme is that we not only discuss a variety of issues, but we can take loans from its credit programme to invest in various income-generating activities. For example, I personally borrowed Tk. 2000.00 and purchased a sewing machine. I can repay my loan amount from the earnings I get through the use of the machine. Moreover, my educational expenses are also met through these earnings.

I like the CWFP's programme since it helps make adolescents aware of themselves. The elders usually do not want to undertake any such programme for us, since they consider us minor and immature. But we can learn a lot from the CWFP programme. We have learned about the demerits of early marriage and the dowry system. Many parents consider early marriage for their daughters a way of unburdening their responsibility, since upkeep and education require monetary investments. If a good groom is found for a young daughter, the parents think that education is no longer required. Thus, they feel compelled to arrange the marriage, and conserve family resources. But I think if the girls could become self-reliant and support themselves financially, their parents would not insist on getting them married so quickly. Now, we can say that we will not marry at early ages as our elder sisters were compelled to do so.

Finally, we have learned about health – for example, the benefits of immunization. Our elder sisters did not receive Tetanus Toxoid for immunization, because they did not know about the benefit of it. We get immunizations, because we know about their benefit and importance. So, I would like to say that the donors who support CWFP could further intensify their support, so that it will help many other girls, like us, to learn more and get better opportunities in life.

The *apas* of CWFP are working for the country, particularly in helping adolescent girls to attain self-reliance. And helping people attain self-reliance means working toward the benefit of the country. So I thank the CWFP.

Finally, I have never appeared before such a large gathering or delivered a speech. I thank you all for providing me the opportunity to speak to such a gathering. This is really exciting for me. Thank you.

Saiful Islam: Assalamu Alaikum, ladies and gentlemen. My name is Saiful Islam. I am from a suburban area of Dhaka city, Dakhina union under Uttara thana. I would like to share with you some of the experiences I gained through the adolescent programme of Family Development Services and Research (FDSR). On December 1, 1997, I was involved with the Child Welfare Programme of FDSR. Many other adolescents, like me, from my community were also involved in this programme. Before coming here to make this presentation, I had a discussion with my friends. So my presentation is mostly based on the discussion I had with my friends.

Being involved with the FDSR's programme we have learned many things. I am presenting those which attracted us most and which seemed to us most beneficial. We have learned about the physical and mental changes an adolescent has to pass through. Now, I do not think that there is any reason for agonising about these changes. Rather, we have to take this easy and begin to prepare ourselves for a better life.

All these ideas we have learned from the FDSR's Family Life Education (FLE) Programme. Thus, I along with my friends, have recognized FLE as a means for achieving a better life and as a beacon for a prosperous future.

With this, I would like to conclude my speech. Thank you all.

(Presentations were originally made in Bangla. The original presentations are attached as Appendix 3).

Discussion Session

Following is a list of the key questions and issues raised by the participants of the open discussion session. Where possible, the answers (offered by other participants) are also included.

Dr. Khaled Shamsul Islam, School Health Pilot Project, said that several of the adolescent health curricula used by different NGOs had been collected. Then the Director General of Health Services appointed a committee comprising an international expert, a local expert from WHO and two representatives from the National Curriculum and Textbook Board (NCTB). The role of the committee was to review the existing curricula on adolescent health and develop one standardized curriculum. After one and a half years of effort, a curriculum was developed. But NCTB put their reservations in some of the topics of the curriculum. However, a number of topic, such as personal hygiene, cleanliness of premises, ventilation etc., were incorporated into the textbook of Class 6 and Class 7.

I would also like to point out that aside from the cooperation between the Government and NGOs, contributions from other authorities concerned for the welfare of adolescents – such as the Islamic Foundation – will be essential to capture the true sentiment of the people. On the other hand, we should be very careful to use different terminologies and words for adolescents' health education programme. As for example, the word "sex". Generally, we do not use the word openly in any discussion related to sexual behaviour. Keeping in view our social and cultural norms, we need to be very cautious when using these types of words. In this regard, I could mention that one of the NCTB members once categorically restricted using the word "sex" in the adolescent curriculum. So, you can see reality is a bit different from what we have written and shown today with regard to adolescent issues. Keeping in view the social context in which we are working, the educational level of the parents and teachers who reside in the thanas and unions, and finally their perceptions about adolescent health, it is, quite honestly, very ambitious to expect to accomplish all that which has been discussed here.

Mr. Mohammed Ali Bhuiya of ORP inquired whether any of the service providers working in adolescent health had actually provided services to unmarried but sexually active adolescents. He further asked whether contraceptives had been offered to unmarried adolescents and if it is so what had been the social reaction. He was also curious about where contraceptive services could be obtained if the service providers did not offer them.

Mr. Shamsher Ali Khan of BRAC said that, in the school programme, students were asked about their views on the issues. Some of the students expressed the view that they did not want to engage in premarital sex. Others, however, were having sexual relationships with female students. Their teachers disclosed a similar message. However, contraceptives were never offered or given to unmarried students. Some married adolescent students developed a good rapport with their teachers and collected contraceptives from them.

Mrs. Shahin Akhter Dolly of Nari Maitree said that Nari Maitree has an HIV/AIDS prevention programme that provides a regular supply of contraceptives to adolescents girls through clinics. They work mostly with unmarried adolescents and commercial sex workers.

Participants from Marie Stopes Clinic stated that unmarried boys suffering from STDs come to their clinic to freely discuss their problems with the female doctor there.

Dr. Fatema Alauddin of FDSR, reflecting on her experience with the Family Life Education (FLE) group, said that female adolescents exposed to premarital sex are openly ostracised by the adolescents from "good" families.

Mr. Emamul Haque of FPAB said that FPAB has used mass media to promote adolescent health. In 1996, FPAB, in collaboration with the BBC World Service, produced 15 episodes for radio programming. Many relevant health issues, including sex education, were discussed in the programme. This programme was in Bangla. Within a very short time after it was broadcast, FPAB had received six thousand letters, most of which were written by adolescents. FPAB replied to all of these letters. Inspired by this overwhelming interest, FPAB produced and distributed a booklet written on the basis of the programme.

Very recently, FPAB started a project with Bangladesh Television (BTV). Earlier, BTV had barred the programme on sex education or family life education. From the current month, however, BTV is broadcasting a five-episode talk show on adolescent health. In this programme, the adolescents, both male and female, expressed their problems freely. An adolescent girl described how terrified she became during her first menstruation and how she incorrectly assumed that she was suffering from blood cancer. The girl apparently hails from a middle or upper middle class family, but did not have access to any information from her parents or school or from any other reliable sources.

Parents, social scientists and psychiatrists also express their opinions on these issues during the programme. This programme is broadcast every Friday at 10:30 a.m. FPAB is currently engaged in the development of a nine-episode television drama serial on adolescent health and behaviour. This will be broadcast next year. Initiative has also been taken to produce a television magazine featuring adolescent concerns.

Dr. Abdul Baqui, Programme Manager, ESP, Directorate of Health Services, said that the region's culture has changed a lot with the passage of time. A father of the previous generation would not have dared to watch the same television programme that the parents of today's youth watch alongside their children. He, emphasizing the need for health education, proposed the development of a unified curriculum for adolescents under the guidance of the Population Council or the Directorate of Family Planning (DFP). He, in congruence to the statement of Dr. Kamal, said that approach and curriculum should be developed in the light of the religious, social and economic situation of the country.

Dr. Zohora Khanum of UNFPA termed today's programme as a timely measure. She said that adolescence refers to the time period between 9 and 19 years of age. But the problems of a nine-year-old boy or girl and the problems of a 19-year-old adolescent are quite different. A girl aged of 9-10 years is alarmed by her first menstruation. She gets confused. Nevertheless, she tries to conceal the fact and her concerns from her parents. Thus, school is the most logical place to address adolescents. But community

involvement will be required to reach those who do not attend schools. A joint programme of the Ministry of Health and Family Welfare and the Ministry of Education should be undertaken. This would allow for a special, separate curriculum for adolescent health needs.

Mr. Zahurul Islam of Dhaka Ahsania Mission, said that different organzsations are using various materials for adolescent health education. Now the question comes whether there is a need to compile all those to have a set of generic materials. More materials are indeed required. But an effective coordination mechanism among the agencies concerned will be very important. Consensus building on the content of the curriculum will also be essential. But if the approaches of the programme vary, the contents and types of the materials may also vary. And more importantly, the need for materials may vary from community to community and person to person.

Dr. Shameem Ahmed, ORP, said that most organizations are doing school health programmes only in the focussed schools, like government schools. But I would like to bring to your attention the private schools that are run by individuals, where primarily the upper elite class children go. I want to draw your attention to the fact that if you look at substance abuse, drug abuse and so on, more of the children of this group usually do not enjoy much time with their parents. Also, children of this group tend to suffer from deficiencies in love, affection and care from their parents, who instead, show their love by earning money to pay for the tuition demanded by the better schools, and other commodities. I think you should as well target the students of the private schools.

Closing Session

Rapporteur's Report by
Dr. Rafiqus Sultan
Programme Manager, Maternal Nutrition and Adolescent Health
Directorate of Family Planning

Respected Chairperson, Honourable Chief Guest, respected guests, ladies and gentlemen. We are now at the closing session of the First Stock-taking Workshop on Adolescent Health Activities in Bangladesh. We all know that, for a long time, adolescent health was a neglected area in our health and family planning programme. Now, as a component of the ESP, it has begun to receive recognition in the HPSP. Today, we have spent about five hours discussing various adolescent health issues. Specific recommendations have as well, been made for the success of the adolescent component of the HPSP. Now I would like to summarize the key points that have been made throughout the day.

During the working session, six presentations were made covering four broad areas. These areas are:

1. An overview on adolescent health status and the existing adolescent programme
2. The adolescent health programme under the HPSP
3. Government School Health Pilot Project
4. Adolescent programmes being implemented by NGOs (BRAC, Nari Maitree, FDSR and CWFP).

Apart from the GoB and non-government organizations mentioned above, several other agencies, which have been working in the area of adolescent health across the country, discussed their activities. This took place during the discussion session.

More importantly, two adolescents – one girl and one boy – shared their feelings and expressed their expectations to the concerned organizations which have been working for the well-being of adolescents.

From these presentations and the discussion, the following three crucial areas which need programmatic attention were identified:

1. Need for the development and wide circulation of Behavioural Change Communication (BCC) messages to create awareness about reproductive health among adolescents as well as the service providers.
2. Treatment of iron-deficiency anaemia
3. Treatment of certain gynaecological problems, such as dysmenorrhoea

A list of major health and social problems relating to adolescents was identified during the discussion. Participants and discussants expressed their concerns about these problems. The problems discussed were as follows:

a) Nutritional problems

b) Problems relating to reproductive health
   - Menstrual
   - Early and unwanted pregnancy
   - Unsafe abortion
   - Unsafe sex

c) Social problems
   - Violence
   - Sexual abuse
   - Accident
   - Substance abuse

After reviewing the experiences gained by both GoB and NGO efforts, a number of key issues were identified. These are as follows:

- Adolescents need AFLE both in formal and non-formal education settings
- A curriculum needs to be developed as a joint effort between all stakeholders (parents, teachers, healthcare professionals and adolescents)
- The AFLE curriculum developed by VHSS and BRAC needs to be revised through community participation
- Involvement of the community (parents, teachers and community leaders) is essential in the adolescent programme
- Work needs to take place through community group formation, selection of leaders and counsellors
- The involvement of adolescent boys needs to be solicited for the programme
- Issues, such as smoking, substance abuse and gender issues (dowry, violence etc.), need to be given special focus for the programme
- Consensus-building activities and written understandings need to be initiated
- Careful attention to the building of a sense of programme ownership needs to be given
- Reproductive health services (clinical services, counseling and health education) need to be integrated with skill development training, legal aid and credit programmes
- Linkages need to be established between those NIPHP NGOs (both urban and rural) that are planning to launch programmes for adolescents
- Recreation and reading facilities need to be provided at youth clubs
- Peer networks need to be established

Recommendations

Following is the list of recommendations put forward at the workshop:

- Prepare a database of organizations working with adolescents
- Undertake studies on married and unmarried adolescents
- Conduct orientation of elected representatives (policy advocacy)
- Place special thrust for Behavioural Change Communication (BCC) activities
- Establish a kishoree pathagar
- Ensure inclusion of middle class (apart from focusing targeting only the low socio-economic group)
- Encourage collaboration between individual interventions as a means of monitoring programme outcomes
- Promote a multi-sectoral approach by the Government
- Broaden the government programme
- Increase the use of the media
- Coordinate with religious groups

Address by Ms. Margaret Neuse
Team Leader, Population and Health Team,
USAID, Dhaka

Mr. Chairperson; Director General, Family Planning; George Fuchs, Interim Director, ICDDR,B; Dr. Barkat-e-Khuda, Chief of Party, ORP; presenters; and participants. Thank you very much for inviting me to participate in this closing session. I am extremely pleased to be able to at least observe. During the past hour and a half, I cannot say that I have participated in the discussion. Nevertheless, I am extremely pleased to witness the kind of exchange and interchanges that have been taking place; to get a glimpse of the kinds of issues that you are already getting into and have presented during this final session.

Let me just highlight a couple of issues as I see them from the perspective I had working in Washington developing a programme on adolescence for USAID – and now, looking at what we are trying to accomplish here for adolescents in Bangladesh.

First, why are we interested? What is special about this group? It has been mentioned that adolescents can be considered an under-served group. Moreover, the group has merited special interest and has emerged as a priority during the last five to ten years because we are now facing the largest generation of adolescents ever in the history of the world. The behaviour of this generation of adolescents is going to affect everybody's future into the next generation. This is one factor. We've also learned a lot of other important things. The adolescent group is the one most affected (in most countries) by HIV/AIDS. So there are particular concerns in terms of the sexual and reproductive behaviour of this group. We have also learned that maternal health and survival of this group's children is affected by what happens during the adolescent years in terms of nutrition and other behaviours. So working with adolescents, in the long run, will have an impact on neonatal health and neonatal survival in Bangladesh as well. So there are a number of reasons that the things we are learning have broader implications for this under-served group and make it imperative that we look at how we can best serve them.

Now we face the question: How can we do this? We tend to think of adolescents as a homogenous group – which, I think, we have learned that they are not. Rather, this is a large and diverse group. We tend to think about our task in terms of the older part of the adolescent group. But there are also the young adolescents to be considered. And there are major differences in what they need and what they want. There is a large difference between 10-12-year olds, 13-15-year olds, and 18-20-year olds adolescents. The challenge then, for us, is to figure out how we can meet the various needs of the different age groups.

We have talked a lot today about in-school adolescents and out-of-school adolescents. How do we address the needs of these very different groups? How do we address the different needs of adolescents from urban vs. rural, rural vs. somewhat rural, and urban metro vs. urban centres or thanas and districts? And clearly, there is a big difference here between married and unmarried adolescents and their respective needs. The challenges lie in delaying marriage and addressing the needs of those adolescents who have already married. On the other hand, the needs of the different target groups and sub-groups are such that we have to be flexible and adaptable. And these needs do not just relate to health. That is our challenge as people who work primarily in health.

Adolescents may not perceive their highest priority on health issues. Rather, it could be career, it could be education, it could be any number of things besides health.

Adolescents also are seen – particularly if you look at all the different adolescent age groups – as still being dependent or only beginning to evolve in their independence. The gaining of independence becomes a question for parents and other stakeholders in the lives of the adolescents. So we have another group of people to be concerned about. It is not just the adolescent himself but his/her parents, his/her peers and other groups that relate to him/her and influence him/her. Adolescents tend to listen primarily to each other. And to work, and be very effective, you need to recognise the importance of peer groups. I think that it has generally been the case in urban areas that peer education has become a reasonable approach to the delivery of adolescent services.

All in all, we have to conceptualize a whole array of needs as we think about developing an effective adolescent programme, even as we think about it from the perspective of the health sector. One underlying need is to look at addressing the needs, remembering that resources are limited. This is the largest group of adolescents ever in the world. We all recognize that there are many obstacles to meeting their needs. But at the same time, we recognize the need to do so. The fact of the matter is that resources from donor agencies and governments are not increasing at the same rate as the adolescent population and therefore, we have to figure out how, within the constraints of the given resources, to address those particular needs within the context of our programmes. And those needs as I think you have mentioned are:

One. Information. How do we get it? The clients (adolescents) need a lot of information about a lot of different topics, about a lot of things they need to understand to develop behaviours that will serve them well throughout their lives. These are behaviours they need to start practising now, if they are going to have a healthy future, both for themselves, their families and their children. So we need to figure out how we can get the information to them, how we can get them the services they need, how we can get them to actually behave in ways that are beneficial to themselves and their families. Be it for family planning, for nutrition or for jobs, be it for education or any other important message.

The fact that they need these things and the fact that we have a lot of different things going on – demands that we take another look at how we programme. There are reviews already available, on the experiences of adolescent programmes world wide. But let us just stick to what is happening in this room and the programmes that are being implemented here in Bangladesh. What have we learned here? First of all, we tend to find – and I think this is the experience of many in this room – that the programmes are small scale, pilot activities targeted to a small group in a particular geographic area for a particular group. Therefore, they tend to be low-impact. That is one issue.

The second thing is that they do not tend to be well evaluated. We do not do a very good job analyzing or researching what it is we are learning and assessing impact. Further, we do not share information very well; we are not well publicised. There is the need for better exchange – ongoing exchange of information, plans, activities, curricula – as well as details about just how we are going about implementing the programmes. So we have large challenges ahead of us, because, in the millennium, we want to be able to coordinate and link our efforts together.

Another essential programme need is linkage. You need to improve the linkage you have among you, because not all of you are experts at everything. If one organization is particularly good in service delivery, that does not mean that it is also an expert in information dissemination or IEC/BCC. If another is very strong in school curricula, maybe still another could link with it by providing a service intervention. So I think we need to rely on linkages. I must also mention the importance of linkages even among ourselves. Linkages are also possible with those groups who do micro-credit programmes, who do other kinds of educational programmes, who do other kinds of income-generating activities, where you might affect a particular target group.

We also need to figure out how to use linkages effectively in the delivery of health services. How can we make our services adolescent friendly? If you walk into a clinic, you see primarily women with their babies and women who are well into their reproductive years. Adolescents – particularly those, who are unmarried, are not going to go to one of those clinics – even a satellite clinic. This is because they face very real social challenges. People in tight-knit communities tend to discuss where their neighbours are, and an adolescent will tend to believe that his or her neighbours know why he or she is going to the clinic. There is a very strong need for privacy, which can be difficult to achieve.

One other factor in terms of evaluation that I would like to mention is that we also tend to not be very clear about what, exactly, our objectives are. We need to be very clear about the objectives and the indicators so as to assess whether or not the objectives have been met. This is a critical basis for real evaluation and impact assessment.

One final important factor – which I am very pleased about in this particular meeting – is to include adolescent representatives. I think services and information must truly be adolescent friendly. We need to involve adolescents right from the beginning in the planning, designing and implementation of the programme.

What do we remember about our own adolescence? I do not remember much. I mean, I try to forget most of my own adolescence. The experience of adolescence in the nineties is quite different, even in Bangladesh, than it was for me or for you. This is because we have undergone so much change in such a short time. Most of us experienced adolescence in the forties, fifties, sixties – even in the seventies. Our experience was very different from today's adolescents who are experiencing the nineties and moving into the year 2000. So we need to make sure that we listen to what the adolescents themselves have to say and make sure that we are responsive to what they think about in planning, designing and implementation. I think this is really important.

So, I think we have a lot of work to do. But we have a lot of committed people, who are very interested in this area and understand what is ahead of us and the challenges that are being faced. I am extremely pleased by the fact that the Ministry of Health and Family Welfare is becoming an active participant in this process of thinking about and looking at options and how they can work in the future. I am particularly pleased by their interest in coordinating and making sure that the limited resources that we have in this area are carefully utilised; that we build on the experiences we gained today, and that we learn from what we have done as we progress and find new and different things that will help us create a strong and effective adolescent programme for the next century. Thank you very much.

Address by Professor Barkat-e-Khuda,
Chief of Party
Operation Research Project, and
Acting Division Director, Health and Population Extension Division
International Centre for Diarrhoeal Disease Research, Bangladesh

Chairperson; Director General of Family Planning; Team Leader, Population and Health Team, USAID; Interim Director, ICDDR,B; Distinguished Participants.

Let me reiterate some of the major issues concerning adolescent reproductive health.

As we all know, adolescence encompasses the transition from childhood to adulthood. Indeed, it is one of the most crucial periods in an individual's life. During this period, many key (social, economic, biological, and demographic) events occur that set the stage for adult life. Until the age of 10 years, most children live at home go to school, have not yet reached puberty, and are unmarried. By the age of 20 years, most have left school and home and, if they have not married, have become sexually active. Thus, this 10-year period is a crucial one. The quality of their futures depends largely on the extent to which adolescents take advantage of opportunities for personal growth by going to school and being employed while avoiding potentially problematic outcomes of sexual relations, such as early dropout from school, unplanned pregnancy, or adverse health effects.

In the developing world as a whole, the adolescent population (10-19 years of age) is estimated at around 950 million. In Bangladesh, adolescents account for about 22 percent of the total population, i.e. about 28.5 million of an estimated total population of 125 million.

Recently, the wide recognition of the benefits of education for individuals and societies has led to a rise in parental demand for children's schooling and to large new investments in the education sector by many governments. As a consequence, school attendance has risen substantially over the past three decades in virtually all developing countries. This is also true of Bangladesh. Bangladesh has made great strides in the education sector. There has been a several-fold increase in school attendance, both at the primary and secondary level and for both boys and girls, although the situation is still far from satisfactory. A key implication of the rising trends in education is that increasing proportions of the period of adolescence are spent in school.

Marriage marks the beginning of socially sanctioned sexual relations and exposure to the risk of childbearing in most societies. The median age at marriage for women in developing countries ranges from less than 16 to 22 years. The proportion of girls who bear a child before the age of 20 years varies widely between developing countries. In a few countries, this proportion reaches as high as two-thirds (for example, in Bangladesh); whereas in other countries, fewer than one-fifth give birth before the age of 20 years (for example, in Sri Lanka).

Because of the physiological and social immaturity inherent to adolescence, the health risks associated with childbearing among this population segment are more pronounced than they are among older women, regardless of their marital status. In most cases, these health risks are exacerbated by a lack of appropriate prenatal care.

Nevertheless, public attention tends not to focus on the potential dangers of immediate post-pubertal childbearing among young, married women largely because of strong barriers (social, cultural and religious) that exist to acknowledging them openly as well as to addressing their root causes.

Not much is known about the reproductive behaviour of unmarried adolescents in Asia, because questions about reproduction and sex are typically asked only of those in unions. Nevertheless, the introduction of garment factory work in Bangladesh and elsewhere in the region is, for a relatively large number of women, creating opportunities during adolescence that they would not have otherwise expected. By working outside the home and by generating their own income, these young women are experiencing a radically different transition into adulthood than are their homebound counterparts, who are socialized for the traditional pattern of early marriage and childbearing. Young women working in the garment factories develop peer networks that act as sources of information and support. These peer groups can help the individual adolescents evaluate alternative opportunities, including those relating to marriage. The critical reproductive health implications of participation in the garment labour force are delayed marriage and delayed childbearing because of the high opportunity costs that women associate with leaving the work force.

To make reproductive health programmes for adolescents more effective, programme designers must understand how adolescents think. A review of the literature and the information presented by various speakers today have pointed out many important decisions that adolescents face today. Although some adolescents appear to weigh the pros and cons of engaging in certain behaviours, not all decisions are made rationally. Much of adolescent participation in unprotected sexual intercourse may, in fact, be due to a simple failure to make a decision (or the making of default decisions) because of ambivalence about pregnancy or STDs, particularly among younger adolescents. As part of their decision-making process, adolescents often look to their teachers, peers, and school environment for clues regarding various aspects of sexual behaviour and to evaluate the degree to which their beliefs agree or disagree with group norms. Consequently, schools offer a very important setting for study. For the large numbers who are not in schools, however, community-based intervention is needed.

Health programming in the past has fallen short of helping young people acquire the knowledge, skills, and behaviours they need to begin their lives as proactive adults. The current national health and population programme (HPSP and NIPHP), however, is attaching high priority to addressing the reproductive health needs of adolescents.

Several recent reviews point out that not enough is known about the effectiveness of current interventions and that a need exists for more rigorous evaluations of the existing programmes and for new prospective studies to test alternative models.

This workshop has reviewed the findings of adolescent programmes of the Government and several NGOs with the overall objective of identifying effective interventions for implementation. The ORP, in collaboration with the Government and the NIPHP rural and urban service delivery partners, will be conducting a detailed assessment of the reproductive health needs of adolescents. ORP will also be collaborating with ICDDR,B's other programmes. Information from the needs assessment will be used in designing appropriate interventions to address the specific adolescent needs at the community, school and clinic levels, and for the various segments of the adolescent population (married/unmarried, male/female, in school/not in school,

working/unemployed, etc.). ORP will be placing particular emphasis on developing strategies and conducting operations research on those strategies in the government and NGO field sites.

Let me take this opportunity to thank everyone for their valuable contributions to this workshop. In particular, I would like to thank Dr. Jahir Uddin Ahmed for taking time off from his other engagements to chair the workshop. My thanks are also due to the Director General, Family Planning; Line Director of ESP from DGHS; Team Leader, Population and Health Team, USAID; Interim Director, ICDDR,B; and my colleagues from DFP and ORP.

Address by Professor George Fuchs
Interim Director
International Centre for Diarrhoeal Disease Research, Bangladesh

Thank you. I am glad to have had the opportunity to join this workshop during the closing ceremony. I think this workshop clearly demonstrates the unique advantage of having a sector approach to health issues. You have shared success stories and lessons learned from ongoing interventions by the Government and NGOs addressing adolescent health issues. ICDDR,B is proud to have been allowed to join the government in the organization of this endeavour.

There are recent examples of health promotion campaigns for population and family planning, immunization and oral rehydration in Bangladesh. I believe these campaigns have reached young people, even though most campaigns were directed at married couples with children. Most people in this room today would agree that specific campaigns and programmes for adolescents are needed.

The Centre shares this view. Several scientists at ICDDR,B are planning studies in the area of adolescent health. One is being planned on peer education for HIV/STD prevention among the youths of Dhaka. Another plans to collect information from unmarried adolescents in three main areas: reproductive health and health service use, nutritional deficiencies, and food intake. As you know, ORP is conducting needs assessment studies in urban and rural areas and working with the GoB and NGOs on the adaptation and design of reproductive health interventions. We will periodically produce materials and organize briefing seminars and other events to disseminate the findings of these research activities.

The work that we are doing in the area of adolescent health is part of our strategy of addressing issues of reproductive health within the framework provided by ICPD.

In Bangladesh, like in many developing countries, there are social and religious impediments to interventions for improving services and information to adolescents on issues, such as reproduction and sex. In these countries, also, the period of adolescence, in general, tends to be less recognized, because economic and social pressures shorten the transition from childhood to maturity and self-reliance.

I believe that we need to change our approach so that it addresses adolescents as a special group in need of reproductive health services. This will be an essential prerequisite to ensuring progress in the area of reproductive health.

We need to identify the best way to integrate interventions for adolescents into existing services. We also need to find effective ways to train and offer orientation to health and family planning staff on adolescent health issues and then to monitor progress. This is also the case for interventions aimed at improving the effectiveness of education on personal development at schools and in community settings.

The agenda for adolescent health interventions should not be restricted to the provision of information on health programmes and biological development to adolescents from adults. Both international and national experiences have pointed out the usefulness of peer education; child-to-child programmes that have been successful in improving knowledge.

I wish you success and reiterate the pride felt by the Centre in being part of this partnership for adolescent health in Bangladesh.

Address by Chief Guest
Mr. Md. Shirajul Islam
Director General, Directorate of Family Planning

Bismillah-hir-Rahman-ir-Rahim. Mr. Chairperson; Dr. Jahir Uddin Ahmed; Prof. George Fuchs, Interim Director, ICDDR,B, Prof. Barkat-e-Khuda; distinguished participants; my colleagues; ladies and gentlemen; Assalamu Alaikum.

I am very happy to be here in this closing session of the First Stock-taking Workshop on Adolescent Health Activities in Bangladesh. In fact, adolescent activity has come under the spotlight, so to speak, because it has increasingly important implications – particularly in developing countries. Since Bangladesh is a developing country, we naturally have concerns in this area. A nation's development depends heavily upon the health of its young generation. In Bangladesh, adolescents constitute 23 percent of the total population. In the past, however, we did not give proper attention to adolescent health. Some of the speakers have referred to it as a neglected area. Rather, I would say that it has simply been underserved. When I was Joint Secretary in the Ministry, I pointed out on a number of occasions and meetings with agencies such as ICDDR,B and Pathfinder, that adolescent health is an underserved area. And finally, to our great satisfaction, the adolescent issue has been addressed in the Health and Population Sector Programme with due emphasis.

Now let us discuss the provision of health services to adolescents – especially the unmarried adolescents in our country. When an unmarried adolescent requires health services, how will he/she get them? If an adolescent goes to a clinic – particularly to a government clinic – for services related to a sexually transmitted disease, he/she will be required to disclose his/her identity. Without personal identity, the government service providers will not provide services. In such cases, however, the unmarried adolescents would generally prefer not to disclose their identity. This is a problem and more so in the government clinics, because, without proper identification, services related to pregnancy or sexually transmitted diseases cannot be delivered. This is so because if it were not, members of the community, along with religious leaders, would immediately organize efforts to resist it. In today's Bangladeshi society, if somebody were to claim that the government was allowing the provision of such services to unmarried men or women, there would be a great public outcry. However, we do recognize that there are cases – though very few in number – that unmarried men and women do receive services.

Now let us have a look at NGOs. With regard to service provision, they have some flexibility. No one – either married or unmarried – who comes to an NGO clinic for healthcare, is required to provide their identity to the clinic staff members. This is the basic difference between the government institutions and NGOs. Because of this flexibility, NGOs, to some extent, have taken the lead in this sensitive area. NGOs are approaching the people – making an impact on their attitudes. So if we see that things are changing and NGO programmes are indeed successful, the government will naturally follow by replicating the successful components of the NGO programmes.

We are speaking about sexuality among unmarried people. We could not have conceivably discussed such a topic five to ten years ago, even at the district level. Now we can discuss it in some selected areas, like Matlab and Mirsarai, where ICDDR,B has been doing research on these topics. Therefore, we should proceed slowly. I am

optimistic that things are moving in the desired direction. Nevertheless, we cannot expect to achieve change overnight, even with regard to the service providers. Indeed, service providers will need to be motivated and educated as well. It will take more than lectures to successfully motivate service providers to change their attitudes and practices. Thus, the programme's initial enthusiasm must be maintained with regard to this critical issue.

From a government point of view, the target for the fourth population programme was on children and married women. We never imagined providing services to unmarried men or women. Adult family members tend to believe that adolescents do not require these types of services. Now, however, we feel that adolescents should be provided with services. Therefore, the adolescent health issue has been incorporated in the ESP. In this stock-taking workshop, both government and NGOs have shared with us their experiences in delivering services to adolescents; the methods they used to motivate people and the difficulties they faced. It would be worthwhile for the national programme to heed these experiences. Through them, we can gain important knowledge. If we tap into this great resource, it will help us meet the challenges we will inevitably face in the coming years to bring about a successful adolescent programme in Bangladesh.

The government is committed to working in this area. This commitment, you know, is based on the global commitment. The community approach was agreed upon in 1994 in the International Conference on Population and Development (ICPD) in Cairo. To maintain this commitment, we have to conduct basic qualitative and quantitative research. Being a research arm of government, ICDDR,B is going to undertake research studies in this field. Here I should mention that identifying the crucial needs of the adolescents is considered to be important for the designing of programmes to serve adolescents. These needs will be identified through research. I also want to point out that the researchers have to work on challenging the existing social taboos. In doing so, they will need to identify social and cultural barriers.

In light of the ESP, we need to identify – in order of priority – those services to be introduced in the adolescent programme. One of the speakers, today, was talking about the need of information, education and communication (IEC) or BCC) materials. We know that IEC/BCC materials can bring about behavioural change. But we have not yet identified what sorts of IEC/BCC materials will be developed to address adolescent health. However, we are saying that separate IEC/BCC materials will be required for men, women, children and adolescents. Thus, we will have to design and develop IEC/BCC materials very carefully, so that they successfully address the most crucial needs of the relevant target audience.

Now let us discuss the service-delivery strategy in light of the ESP. We will need to conceptualise and design strategies on how ESP services (which include adolescent health) could be delivered from the thana health complex to the Community Clinics, the lowest tier of service delivery. For the ESP, the government will set up 13,500 Community Clinics throughout the country, each covering a population of 6,000. Then we will provide comprehensive health and population services through the clinics. During the first phase, however, a minimum package of services, including basic personal health, will be provided.

Currently, adolescents are at a considerable risk. Programme managers will develop programme schedules in such a way that they allow parents, teachers and social leaders to become involved in the programme. Without the support of the community, it will be really difficult to approach adolescents and be assured of their support and

cooperation in the programme. Due to social changes, which have occurred over time, the adolescents of the fifties, sixties, seventies and eighties are completely different from those of the nineties. Thus, to ensure the effectiveness of the programme, the adolescents of nineties should be heavily involved in the process. It will be essential to know whether or not they are thinking along the same wavelengths as the programme organizers. This will be a very crucial aspect of the programme.

I will try to wrap up my message, since I know you have all been here since morning. So, to conclude, I thank the organizers very much for inviting me to this important workshop. I believe that the cooperation established between the officials of the two directorates, NGOs and the Operations Research Project of ICDDR,B is a clear sign for a good start for the adolescent programme.

I am optimistic that we will be able to achieve the desired success of the programme. NGOs and other organizations are supplementing and complementing the government programme. My special thanks go to ICDDR,B for organizing this workshop. As I recall, for the past couple of years, ICDDR,B has provided support to the government programme. In this sense, they are really one part of the government. The partnership that has developed between the government and ICDDR,B will continue. From a governmental point of view, I can assure you all that the NIPHP and NGOs as well as the NGOs that do not fall under the larger plan of the NIPHP can be assured of continued support from the government. With these few words, once again, thank you all.

Address by Chairperson
Dr. Jahir Uddin Ahmed
Director, MCH Services and Line Director, ESP
Directorate of Family Planning

Respected chief guest, special guest, participants, presenters, discussants, colleagues, ladies and gentlemen and the two adolescent participants, Saifur Rahman and Ratna: welcome. Our two young participants have given very impressive and spontaneous presentations. First of all, I shall congratulate you, because you have made the effort to come here, have spent the day and have shared your opinions with us. Unfortunately, since all of the discussions have taken place in English, you may have missed some of the subtler points. In the future, we will try to include you in discussions that are held in Bengali.

Ladies and gentlemen, thank you very much for your participation in this workshop. I am very grateful that you had the patience to stay with us for the entire day. I am also grateful to each of you for maintaining the time limits set for your presentations.

Ladies and gentlemen, this is probably a record for the government – a first opportunity for them to take stock of the activities of various organizations working in the field of adolescent health. Director General, Family Planning has said, very correctly, that Bangladesh is one of the few countries where NGOs work just like government institutions. From a programmatic point of view, the government never sees NGOs as independent or isolated. We always consider them our friends and we try to help them implement their different programmes, notwithstanding the obstacles we face in terms of financial and resource constraints. And likewise, whenever we approach an NGO or a donor who has flexibility in resources and financial management, they always come forward to help us salvage our efforts. Thus, we acknowledge the contributions they have made in this country for so long. We would especially like to acknowledge the activities being performed by the NGOs, particularly in the field of health and family planning in Bangladesh.

Ladies and gentlemen, this workshop is only the beginning. Under the Health and Population Sector Programme, we will be the focal point in the Directorate of Family Planning for the adolescent health programme. I will make sure that the proceedings of the workshop are recorded, published and disseminated for reference in the development of the action plan. Thus, I would request ICDDR,B to compile and publish the proceedings of today's workshop. I am extremely grateful to our chief guest for his presence here despite his many professional and official commitments. His words and inspiration will lead us to great achievements through the programme. Whenever we need him, the Director General, Family Planning has always been there to offer a helping hand; to support us in our efforts. We go forward with your help and blessing. I should also mention that your support and encouragement has helped a lot in the organization of this workshop. Ladies and gentlemen, I would request those of you who are working in the field of adolescent health to contact us. We are interested in compiling all relevant information available in the area of adolescent health. Please communicate with us and provide us with whatever materials that have available with you. Feel free to contact me directly or Dr. Rafiqus Sultan, Programme Manager, Maternal Nutrition and Adolescent Health.

Ladies and gentlemen, I am very much grateful to ICDDR, B – and especially to ORP. I knew Dr. Barkat-e-Khuda for a long time. We met when he was working in University Research Corporation (URC). As a Bangladeshi citizen, he looks into health and family planning issues critically. Being the Chief of Party of ORP and acting Division Director of the Health and Population Extension Division (HPED), we can be assured that he will continue to help us in adolescent health activities, wherever possible. We will take the opportunity to disseminate ORP's research findings, as has always been the case. We have implemented many of the findings achieved from the ICDDR,B's former MCH-FP Extension Projects. This is not to mention that some of those activities have been incorporated in the present programme.

I would like to thank the representatives of donor agencies who have kindly attended the workshop and also the representatives of NGOs and private organizations, officials from Health and Family Planning and other organizations. Though we were given very short notice, this workshop has been very productive and fruitful. Being the Line Director, ESP, I believe this will help guide us in our planning, at least for the first year. I hope we will meet again. I have requested Dr. Barkat-e-Khuda to organize another workshop some time during the latter part of next year. There, the progress of first year of the programme will be reviewed and the results will be disseminated to the government and donors.

Ladies and gentlemen, I am very grateful to ICDDR,B for providing this venue for the workshop. Also, I am grateful to others of you who have worked so hard to help us with necessary equipment and facilities. Ladies and gentlemen, once again I would like to thank the chief guest, the special guest, the participants and especially my colleagues at ORP, ICDDR,B and the ESP programme in the Directorate, who have contributed a great deal to the success of this workshop.

Appendices

Appendix 1

An Overview of

of

Adolescent Health Status and Existing Adolescent Health Programmes in Bangladesh

ESP-Reproductive Health
Directorate of Family Planning
and
Operations Research Project, ICDDR,B

Definition of Adolescence

WHO has defined 10-19 years as adolescence. The period is marked by the following characteristics:

- Biological development from the onset of puberty to full sexual and reproductive maturity
- Psychological development from the cognitive and emotional patterns of childhood to those of adulthood
- Emergence from the childhood state of total socioeconomic dependence to one of relative independence

	World in 1995*		Bangladesh in 1996**	
	Million	Percentage	Million	Percentage
Population	5,881	-	122.9	-
Adolescent	1200	20.40%	30.36	24.70%
Male adolescent	612	51%	15.48	51%
Female adolescent	588	49%	14.88	49%

* **Source:** WHO
** ***Source:*** BBS, 1997 and BDHS 1996-1997

Significance of Adolescent Population

- One in every five persons on the earth today is an adolescent
- Adolescents are, at the same time, the present and the future
- Adolescents are at increasing risk of unwanted pregnancy and contracting STDs, including HIV/AIDS

Facts and Figures

- Half of all 15-19-year-old females are married
- Median age at first marriage women – 17.5 years
  men – 25.0 years
- Age at first birth is 16 years per one-fifth of all births are to teenage mothers
- Teenage fertility is still very high
- Thirty-one percent of teenage girls are mothers, and another five percent are pregnant with their first child
- Contraceptive prevalence rate among married adolescents is 31 percent
- The unmet need for contraception among married adolescents is the highest
- The mean interval between marriage and first birth is 13 months
- High risk associated with early childbearing

- Maternal mortality ratio is 3-4 times higher in adolescent females aged less than 18 years among older women
- Low birth weight is more common among babies born to adolescent mothers than to adults
- There is a paucity of data on the incidence and prevalence of other medical conditions
- Half of the married adolescent girls aged 15-19 years are undernourished
- Some sources suggest that premarital sex among adolescents is substantially higher for males than it is for females and higher in urban than rural areas
- We don't have enough information about what adolescents actually know about reproductive health
- Information about adolescents' knowledge and practice regarding personal hygiene is not available; however, unhygienic practices during menstruation are reported
- The health and family planning programme has traditionally been focused on married women and children

Major Health Problems of Adolescents in Bangladesh

- Nutritional deficiency- especially iron and iodine deficiency
- Early and unwanted pregnancy
- Menstrual problems
- Maternal mortality related to early and unwanted pregnancy
- Complications of unsafe abortion due to unprotected and unwanted sexual activity
- RTI/STDs related to unprotected sexual activities
- Addiction to tobacco, alcohol and certain narcotic drugs
- Accident, violence and sexual abuse

Adolescent Health Programme under the HPSP

- Development and wide circulation of BCC message to create awareness about
  - The reproductive process
  - Safe sex
  - STD/HIV/AIDS
  - Proper nutrition and hygiene
  - Proper sibling care
  - Adolescent contraception
  - Demerits of early marriage and early childbearing
- Treatment of iron-deficiency anaemia
- Treatments of certain gyneacological problems, such as dysmenorrhoea

Main NGOs with Adolescent Health Programmes

Name	Target	Programmes
BRAC	boys and girls	AFLE
FPAB	boys and girls	AFLE
CWFP	girls	AFLE, adolescent health clinic, TT services, skill training and credit activities
FDSR	boys and girls	AFLE
BWHC	girls	AFLE, adolescent health clinics, income-generating activities, skill training, credit programme
NM	girls	AFLE, adolescent health clinics, income-generating activities, skill training, credit programme
OMI	girls	AFLE, adolescent health clinics, income-generating activities
WV	girls	AFLE
PSTC	girls	AFLE
CMES	girls	NFPE
CDS	girls	AFLE
Marie Stopes	girls	Health clinics

Findings of NGO Adolescent Programmes

- AFLE is the main activity of most NGO adolescent programmes
  - AFLE programmes have attracted wide attention
  - Girls trained in AFLE are more knowledgeable and more vocal about MCH and gender issues than girls not trained
  - Most AFLE programmes do not have regular monitoring or evaluation
  - Most organizations have been using the AFLE curriculum developed by VHSS
  - The training approach to AFLE has been lecture-oriented and not participatory
- Some NGOs have established separate health clinics for adolescents
- Some NGOs have skill development and credit programmes and income-generating activities for adolescents
- Parents and communities are generally supportive of the adolescent programmes
- Most programmes are focused on adolescent girls
- The effect of most adolescent programmes has not been adequately documented

The Future Needs

- In-depth information on reproductive health-related knowledge, attitude and practices among unmarried adolescents needs to be collected
- More programmes should be designed to target adolescent boys
- The healthcare system should give adequate attention to address the health needs of adolescents
- Efforts to improve services for adolescents should be complemented with campaigns targeting older groups in the community (e.g. parents, guardians, teachers)
- Interventions to design document and evaluate adolescent programmes need to be tested

The Operations Research Project's Current Plan about Adolescent Health

- Conduct a detailed assessment of the reproductive health needs of adolescents
- Work with GoB, RSDP and UFHP to develop strategies to address the reproductive health needs of adolescents

Appendix 2

School Health Pilot Project:
A Project of Directorate General of Health Services

Objectives

- To provide school children with health education as part of their regular curriculum, along with basic health promotion, prevention and screening services;
- To provide first-aid services in schools and to refer, when necessary, for curative care, to providers trained in the case management of school-aged children;
- To provide a safe and healthy learning environment and a supportive learning atmosphere (safe water and adequate sanitation through collaboration and coordination with other projects)

The School Health Pilot Project was designed according to Master Plan 1993

Project duration:	1996-1998
Funded by:	GoB and SIDA
Project sites:	4 districts (Jessore, Faridpur, Comilla, and Bogra) covering 8,000 schools and 2.2 million school children

Components of the School Health Pilot Project

- School health services (e.g. first-aid, deworming, immunization, micronutrient supplementation)
- Healthy school environment (e.g. safe water supply, sanitation, adequate lightening and ventilation)
- Health education (e.g. curriculum development and incorporation into the school textbook, training programme, IEC messages)

Health Education

Different stages of training

Master TOT - 3
TOT - 161
Teacher's training - 8,000
Training of field staff - 200

Topics Covered Under Health Education

- Personal hygiene and cleanliness
- Safe water
- Sanitation
- Food and nutrition
- First-aid
- Common ailments
- Referral
- Population education
- STDs/HIV/AIDS

Current Status

- Curriculum developed and several components incorporated into the textbooks through the help of NCTB
- Master TOT completed
- TOT completed
- Teacher's training partially completed
- Distribution of first-aid box completed
- Health card and referral forms distributed to schools
- IEC materials developed and distributed
- SHPP incorporated into HPSP as a component of Child Health under ESP

Appendix 3

দুইজন কিশোর কিশোরীর বক্তব্য

রত্না, দলীয় সদস্য, সি ডাব্লিউ এফ পি-এর কিশোরী কার্যক্রম, সাইফুল ইসলাম, দলীয় সদস্য, এফ ডি এস আর-এর কিশোর কার্যক্রম

রত্নাঃ

আস্‌সালামু-আলাইকুম। আজকের এই কর্মসূচীটি অনুষ্ঠিত হচ্ছে মূলতঃ উঠ্‌তি বয়সী কিশোর-কিশোরীদের বিভিন্ন সমস্যা নিয়ে আলোচনা করার জন্য। অনুষ্ঠানটি বাংলায় হলে ভালো হতো। কারণ তা ইংরেজীতে হওয়ায় এর অনেক কিছুই আমরা বুঝতে পারিনি। যাহোক, আমি এখন সি ডাব্লিউ এফ পি-এর কার্যক্রম সম্পর্কে আমার কিছু অভিজ্ঞতার কথা বলবো।

আমি সি ডাব্লিউ এফ পি-এর কিশোরী কার্যক্রমের শুরু থেকেই জড়িত, যা ১৯৯৭ সালে শুরু হয়। কার্যক্রমের একেবারে শুরুর দিকে সিডাব্লিউএফপি-এর আপারা কিভাবে কাজ শুরু করেছিলেন আমি এবার সে-সম্পর্কে বলবো। প্রথমে তাঁরা বিভিন্ন জায়গায় গিয়েছেন কিশোরীদের নিয়ে দল গঠন করার উদ্দেশ্যে। তারপর তারা কিশোরীদের সাথে বসেছেন বিভিন্ন বিষয়, যেমন কিশোরীদের শারীরিক, মানসিক, সামাজিক সমস্যা, ইত্যাদি, আলাপ আলোচনা করার জন্য। একজন কিশোরী হিসেবে অনেক অজানা বিষয়ে আমাদের মনে অনেক সময় উদ্বেগ এবং বিভিন্ন প্রশ্নের সৃষ্টি হয়। আমরা এসব সম্পর্কে জানতে চাই, আমাদের প্রশ্নের উত্তর পেতে চাই এবং এসব বিষয়ে পরিস্কার ধারণা পেতে চাই। সামাজিকতা ও লজ্জার কারণে বড়দের কাছ থেকে এসব বিষয়ে আমরা কিছু জানতে পারি না। এরকম একটা অবস্থায় সি ডাব্লিউ এফ পি-এর আপারা আমাদের বিশেষভাবে সাহায্য করেছেন। তারা আমাদের অনেক উৎসাহ দিয়েছেন, সাহস যুগিয়েছেন যাতে মনের মধ্যে লুকিয়ে থাকা অজানা বিষয়ে আমরা তাদের প্রশ্ন করতে পারি। আমরা এভাবে তাদের কাছ থেকে অনেক কিছু শিখেছি। যেমন বয়ঃসন্ধিকালে মেয়েদের যেসব শারীরিক ও মানসিক পরিবর্তন ঘটে থাকে তাদের কাছ থেকে সে সম্পর্কে আমরা জেনেছি। আমাদের শিক্ষা প্রতিষ্ঠানগুলো যেমন স্কুল-কলেজ ইত্যাদির পাঠ্যক্রমে এসব বিষয়ে শেখানোর কোনো অবকাশ নেই।

সি ডাব্লিউ এফ পি-এর কার্যক্রমের আরেকটা উল্লেখযোগ্য দিক হচ্ছে যে তাঁরা বিভিন্ন আয়মূলক কর্মসূচীর জন্য ঋণ দান করে থাকেন। যেমন আমি এ কার্যক্রম থেকে টাকা ২০০০/= ঋণ গ্রহণ করে একটা সেলাই মেশিন কিনেছি। সেলাই মেশিনের আয় থেকে আমি ঋণ পরিশোধ করবো। তাছাড়া এই আয় থেকে আমার লেখাপড়ার খরচও বহন করা যাবে।

সি ডাব্লিউ এফ পি-এর কর্মসূচী আমার ভালো লাগে। কারণ এ-কর্মসূচীর মাধ্যমে তাঁরা কিশোরীদের নিজেদের সম্পর্কে জানতে ও সচেতন হতে সাহায্য করছে । এ-কর্মসূচীর মাধ্যমে আমরা যৌতুকপ্রথা ও অল্প বয়সে বিয়ে করার কুফল সম্পর্কে জানতে পেরেছি। অনেক বাবা-মা সামাজিক দায়বদ্ধতা থেকে মুক্ত হওয়ার জন্য মেয়েদের অল্প বয়সে বিয়ে দিয়ে দেন। এতে তাঁরা একটা সুবিধার কথা বিবেচনা করে থাকেন। আর তা হচ্ছে তার মেয়েটার লেখাপড়া ও খাওয়া দাওয়ার খরচ আর বইতে হবে না। একটা ভালো ছেলে পেলেই তারা মনে করেন যে, ওর আর লেখা পড়ার কোনো প্রয়োজন নেই, এখনই বিয়ে দিয়ে দেয়া প্রয়োজন। কিন্তু আমি মনে করি যে কিশোরীরা যদি আত্মনির্ভরশীল হতে পারে, তাহলে বাবা-মা তাদের অল্প বয়সে বিয়ে দেয়ার জন্য চাপ প্রয়োগ করা থেকে বিরত থাকবেন। অতএব এখন আমরা বলতে পারি যে আমরা আর অল্প বয়সে বিয়ে করবো না।

স্বাস্থ্যের যত্ন সম্পর্কেও আমরা সি ডাব্লিউ এফ পি-এর আপাদের কাছ থেকে জেনেছি। যেমন তারা আমাদের জানিয়েছেন যে টিকা নিলে কি উপকার হয়। আমাদের বড় বোনেরা অনেকেই টিকা নেন নাই। কারণ তারা টিকা নেয়ার উপকারিতা ও গুরুত্ব সম্পর্কে জানতেন না। আমরা তা জেনেছি এবং সে কারণে টিকাও নিচ্ছি। অতএব আমার মতে সি ডাব্লিউ এফ পি কিশোরী মেয়েদের জন্য সার্বিকভাবে একটা বিরাট কাজ করছে। বিশেষভাবে উল্লেখযোগ্য যে তাঁরা কিশোরী মেয়েদের আত্মনির্ভরশীল করতে সহায়তা করছেন। এটা জাতির উন্নয়নে বিরাট ভূমিকা রাখবে। তাই আমার আবেদন, সি ডাব্লিউ এফ পি-এর এই কার্যক্রমে যাঁরা অর্থিক সহায়তা দিয়ে থাকেন তারা যেন এই অর্থ সহায়তার পরিমাণ আরো বাড়িয়ে দেন। তাহলে আমাদের মত আরো অনেক মেয়েদের উপকারে আসবে।

সবশেষে আমাকে এরকম একটা সুধী সমাবেশে কথা বলার সুযোগ দেয়ার জন্য আপনাদের আন্তরিক ধন্যবাদ জানাচ্ছি। এরকম একটা বড় সমাবেশে কখনো কথা বলার সুযোগ আমার হয়নি। আজ যে-সুযোগ আমি পেয়েছি তা আমার জন্য একটা অত্যন্ত উল্লেখযোগ্য ঘটনা। ধন্যবাদ।

সাইফুল ইসলামঃ

উপস্থিত ভদ্রমহিলা ও ভদ্রমহোদয়গণ। আস্‌সালামু-আলাইকুম। আমার নাম সাইফুল ইসলাম। আমি ঢাকা শহরের উপকণ্ঠে উত্তরা থানার অর্ন্তগত দক্ষিনা ইউনিয়নে বাস করি। আজ আমি এখানে উপস্থিত হয়েছি ফ্যামিলি ডেভেলপমেন্ট সার্ভিসেস এণ্ড রিসার্চ সংক্ষেপে এফ ডি এস আর-এর কিশোর কার্যক্রম সম্পর্কে আমার অভিজ্ঞতা তুলে ধরার জন্য। ১৯৯৭ সালের ১ ডিসেম্বর আমি এফ ডি এস আর-এর চাইল্ড ওয়েলফেয়ার প্রোগ্রামের সাথে জড়িত হই। আমাদের এলাকার আরো অনেক কিশোর এই কার্যক্রমের সাথে জড়িত। এখানে কিছু বলার জন্য আসার আগে আমি আমার সেই কিশোর বন্ধুদের সাথে আলাপ-আলোচনা করেছি। বন্ধুদের সাথে আমার যে-আলোচনা হয়েছে তার ভিত্তিতেই আমি আমার বক্তব্য রাখছি।

এফ ডি এস আর-এর কার্যক্রমের সাথে জড়িত হয়ে আমরা অনেক কিছুই শিখেছি। এই বিষয়গুলো আমাদের মনে যথেষ্ট আগ্রহের সৃষ্টি করেছে এবং আমারা এসব আলোচনা শুনে উপকৃত হয়েছি। যেমন উল্লেখ করা যায় বয়ঃসন্ধিকালের শারীরিক ও মানসিক পরিবর্তন সম্পর্কে। এবয়সে এই পরিবর্তনগুলো সম্পর্কে আমরা বিস্তারিত জেনেছি। এসব শোনার ও জানার পর এখন আমরা বুঝতে পারছি যে বয়ঃসন্ধিকালের শারীরিক ও মানসিক পরিবর্তন সম্পর্কে উদ্বিগ্ন হওয়ার কিছু নেই। এটা জীবনের একটা স্বাভাবিক প্রক্রিয়া। এসব পরিবর্তনকে স্বাভাবিকভাবে মেনে নেয়ার জন্য নিজেকে মানসিকভাবে তৈরি করা প্রয়োজন।

এফ ডি এস আর-এর "পারিবারিক জীবন শিক্ষা" কার্যক্রম থেকে মূলতঃ আমরা এসব জেনেছি। অতএব আমি এবং আমার বন্ধু বান্ধবরা এ-বিষয়ে একমত হয়েছি যে আগামী সুন্দর জীবন গড়ার জন্য "পারিবারিক জীবন শিক্ষা" কার্যক্রম একটি অত্যন্ত সহায়ক কর্মসূচী।

এই বলে সবাইকে ধন্যবাদ জানিয়ে আমি আমার বক্তব্য শেষ করছি।

Appendix-4

List of participants

First Stock-taking Workshop on
"Adolescent Health Activities in Bangladesh"

Venue: ICDDR,B Sasakawa Auditorium
Date: October 27, 1998

I. Ministry of Health and Family Welfare

1. Mr. Ziauddin Ahmed Khan
   Project Planning Cell

II. Directorate of Family Planning

1. Dr. Jahir Uddin Ahmed
   Director, MCH Services & Line Director, ESP

2. Dr. A.S.M. Kamal
   Director & Line Director (Planning)

3. Mr. Maqbul Hossain
   Line Director, Behavior Change Communication

4. Dr. Rafiqus Sultan
   Programme Manager, Maternal Nutrition and Adolescent Health

5. Dr. Jafar Ahmed Hakim
   Programme Manager, Clinical FP Services

6. Dr. Mirza A.H.M. Bareque
   Programme Manager, Family Planning Services

7. Dr. Momena Khatun
   Programme Manager, Maternal Health Services

8. Dr. S.M. Jahangir
   Programme Manager (Services & Coordination)

9. Dr. M. Abdul Khaleque Chakdar
   Deputy Programme Manager, Maternal Nutrition and Adolescent Health

10. Dr. Ziaul Karim
    Deputy Programme Manager

11. Dr. Bishnu Pado Dhar
Deputy Programme Manager, Implementation & Planning

12. Dr. K.C. Matiul Alam
Deputy Programme Manager, Quality Assurance

13. Dr. D.M. Enamul Kabir
Deputy Programme Manager, Service Delivery, NGO & Private Sector

14. Dr. Parveen Hoque Chowdhury
Deputy Programme Manager

15. Dr. S.M. Nizamul Haque
Deputy Programme Manager

III. Directorate General of Health Services

1. Dr. M.A. Baqi
Programme Manager

2. Dr. Md. Mozammel Huq
Programme Manager, Child Health & Limited Medicine Services

3. Dr. Md. Asad Uddin
Programme Manager, STD/AIDS

4. Dr. Khaled Shamsul Islam
Ex-Deputy Project Manager (School Health Polot Project)

IV. NIPORT

1. Mr. Mahfuzur Rahman
NIPORT

V. Dhaka City Corporation

1. Dr. Md. Nurul Islam
Urban PHC Project, Dhaka City Corporation (DCC)

VI. NIPHP Partners

1. Ms. Margaret Neuse
   Team Leader
   Population & Health Team, USAID, Dhaka

2. Mr. Richard Greene
   Deputy Director
   Population and Health Team
   USAID, Dhaka

3. Dr. Zareen Khair
   Project Management Specialist
   Population & Health Team
   USAID, Dhaka

4. Mr. Charles Habis
   Population and Development Officer
   Population and Health Team
   USAID, Dhaka

5. Mr. Sk. Belayet Hossain
   Project Management Specialist
   Population and Health Team
   USAID, Dhaka

6. Dr. Fatima Begum
   Pathfinder International/RSDP

7. Md. Habibur Rahman
   Population Services & Training Centre/ UFHP

8. Dr. Mahbubur Raman
   Population Services & Training Centre/ UFHP

9. Ms. Mubarra Matin
   Concerned Women for Family Planning/ QIP

10. Nafisa Lira Huq
    Concerned Women for Family Planning/ QIP

11. Miss Ratna
    Adolescent Participant
    Concerned Women for Family Planning/ QIP

12. Ms. Sanjeed Islam
    Bangladesh Centre for Communication Programmes

13. Mr. Noor Mohammad
    UFHP

14. Dr. Selina Ahmed
    Social Marketing Company

15. Ms. Zahur Fatima
Concerned Women for Family Planning/ QIP

16. Dr. Shamsher Ali Khan
BRAC/ RSDP

17. Mr. Tawfiqur Rahman
BRAC/ RSDP

VII. NGOs

1. Dr. Nazrul Haque
Voluntary Health Services Society

2. Dr. Saqui Khandoker
Bangladesh Population& Health Consortium
NGO Project Office
Partners in Health & Development

3. Ms. Rahnuma Afrin
ACTIONAID

4. Dr. Reena Yasmin
Marie Stopes

5. Mr. Md. Jahurul Islam
Dhaka Ahsania Mission

6. Dr. Fatema Alauddin
Family Develop Services and Research

7. Mr. Girindra Nath Roy
Family Develop Services and Research

8. Mr. Saiful Islam
Adolescent Participant
Family Develop Services and Research

9. Ms. Shaheen Akter Dally
Nari Moitree

10. Ms. Nazrana Yasmin Hira
Nari Moitree

11. Dr. Ladly Faiz
Chief Executive
Population Research & Development Association

12. Dr. Samsad Jahan
Bangladesh Women Health Coalition

13. Ms. Rownok Jahan
Bangladesh Women Health Coalition

14. Dr. Nowrozy K. Jahan
Bangladesh Women Health Coalition

15. Mr. Shoaib Jalil
Family Planning Association of Bangladesh

16. Mr. M. Emamul Haque
Family Planning Association of Bangladesh

VIII. International Organization

1. Dr. Ubaidur Rob
Resident Representative
Population Council

2. Dr. Shaif Md. Ismail Hossain
Population Council

3. Dr. Nahid Chowdhury
Population Council

4. Dr. Zohra Khanam
UNFPA

5. Dr. Jebun Nessa Rahman
UNFPA

6. Dr C.P. Maskey
Team Leader
FPCST/ WHO

The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to program managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of underserved and population-in-need. There are various projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures. These cut across several Divisions and disciplines in the Centre. The Operation Research Project (ORP) is the result of merging the former MCH-FP Extension Project (Rural) and MCH-FP Extension Project (Urban). These projects built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. Together with the Environmental Health and Epidemic Control Programmes, the ORP provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. For one, the public health research activities of these Projects are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve program performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national program at Thana, Ward, District and Zonal levels both in the urban and rural settings.

Operations Research Project (ORP)
Health and Population Extension Division (HPED)
International Centre for Diarrhoeal Disease Research, Bangladesh
GPO Box 128, Dhaka 1000, Bangladesh
Telephone: 871751-871760 (10 lines); E-mail: barkat@icddrb.org
Fax: 880-2-871568 and 880-2-883116

MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. In 1982, the MCH-FP Extension Project (Rural) with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, management information systems, and strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

The Centre and USAID, in consultation with the government through the Project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve t he commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.