Policy Brief January 2021

An assessment of the Advancing Adolescent Health (A2H) Program in Rangpur:
Implications for future interventions

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Contents

The USAID-supported Advancing Adolescent Health (A2H) program implemented by Plan International during 2016-2019 in Rangpur established a foundation for social change to reduce the incidence of early marriage. The program organized foundational life skills training sessions for adolescents that provided information on sexual and reproductive health matters and negotiation skills to address issues such as age at marriage, delaying births, and other behaviors that affect sexual and reproductive health. The program engaged parents, guardians, and community-influential persons through orientation sessions to create an enabling environment for adolescents and improve their negotiations skills on postponement of early marriage. Findings from a quantitative survey, complemented by a qualitative study, conducted in 2018 show that 38% of unmarried 15-19 year-old girls attended at least one of the eight A2H training sessions, while 13% of married adolescent girls of the same age participated in any training sessions. Both the quantitative and qualitative information indicate that the program may have influenced adolescents to undertake activities to postpone early marriage with support from parents and guardians. About 56% of 15-19 year-old girls remained never-married in A2H areas compared to 47% in the comparison areas. Programs like A2H, with some modifications, have the potential for reducing the incidence of teenage marriage in Bangladesh.

A2H is a USAID-supported program that was implemented by Plan International in all of the eight Upazilas of Rangpur District[1] from January 2016 through January 2019. The field implementation was done by two local nongovernmental organizations (NGOs)—Eco-Social Development Organization (ESDO) and Lutheran Aid Mission to Bangladesh (LAMB).

A2H objectives

- Delay age at marriage
- Delay first birth and space between the first and second births
- Improve adolescents' sexual and reproductive health behavior

The theory of change adopted by the A2H program was posited on the assumption that improving adolescents' sexual and reproductive health (SRH) knowledge and negotiation skills within a broader enabling environment would lead to a delay in age at marriage; delay of first birth; improved birth spacing among married adolescents; and improved SRH of adolescents.

A2H interventions

The program had three major intervention components: a) foundational life skills education for unmarried and married male and female adolescents ages 10-14 and 15-19 years; b) orientation sessions for community and family gatekeepers (parents and in-laws); and c) strengthening adolescent-friendly health services and training of healthcare providers in government health facilities. A2H operated through forming 426 community platforms (each containing around 1,000 adolescents) divided into 40-45 groups, each with 15-25 adolescents. There were a total of 267 Community Facilitators (CFs), who were locally recruited to conduct one-hour sessions with adolescents, stratified by age, sex, and marital status. Each 15-19 year-old participant was offered eight life skills sessions, and the 10-14 year-old participants were offered five sessions over a period of about two months. The CFs also conducted orientation sessions for parents, guardians, and community-influential persons. A2H recorded a total of 307,914 adolescents receiving life skills training; and 53,702 parents and community leaders and 4,830 religious leaders receive orientation in the engagement and promotion of sexual and reproductive health, including delaying age of marriage (Plan International, 2018; 2020). In the A2H program areas, 168 public health facilities were made adolescent friendly through provider training, infrastructure improvement, and enhancement of logistic supplies.

[1] The incidence of early marriage in Bangladesh is among the highest in the world, and that in Rangpur Division is among the highest in the country (NIPORT, 2016).

Assessment design

The assessment was limited to examine A2H's influence on behaviors of adolescents ages 15-19 years, since the first two objectives of the A2H program are mostly relevant for this age group in the short run. icddr,b and MEASURE Evaluation conducted a population-based household survey from July-September 2018 (near the end of the program) among 8,501 girls ages 15-19 years in two program areas (Rangpur Sadar and Mithapukur Upazillas) and 3,008 15-19 year-old girls from a comparison area (Nawabganj Upazila in Dinajpur District) (Nahar, et al., 2020). In the program areas, the survey was done in villages where the A2H program was implemented from its initial year and thus the communities were exposed to interventions for about two years. (We assume that the project spent about six months in planning and intervention development.) In the A2H areas, along with a quantitative survey, qualitative data were collected through in-depth interviews (IDIs), focus group discussions (FGDs), and key informant interviews (KIIs) of unmarried and married females ages 15-19 years, unmarried males ages 15-19 years, parents, guardians, and community-influential persons. The comparison area was from a neighboring district which was comparable in terms of marital practice and socioeconomic conditions.

To assess intervention effects, comparison was made between program and comparison areas as well as between participants and non-participants living in the program areas, and those from the comparison area.

Strengths and limitations of the assessment

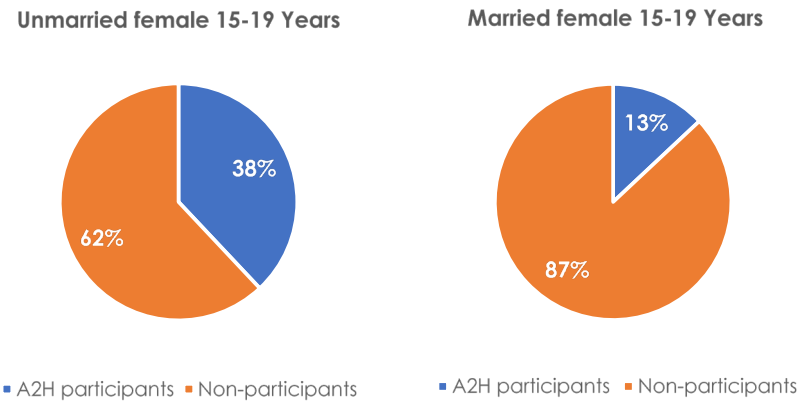
This assessment is based on a one-time survey conducted near the end of the program, complemented by qualitative context-specific information. This design does not allow us to examine change over time. However, the cross-sectional survey in the program and comparison areas allows us to identify adolescents who participated in the life skills interventions, compare them to non-participants in program areas and those from the comparison area, and compare three groups of adolescents on key outcomes. The mixed methods allow us to contextualize findings. It is possible that adolescents who chose to participate in the program interventions had different attitudes and outcomes before the interventions than those who did not participate, so differences in outcomes between the groups cannot be definitively attributed to program effects. The A2H program areas were only exposed to interventions for two years, which is a short period to affect long-standing social norms.

Findings

Participation in the A2H program

- Overall, the participation[2] of unmarried 15-19 year-old girls was low—38%. The level of participation was much lower among married adolescent girls, with only 13% having attended any session (Figure 1).

Figure 1. Percentgae of 15-19 year-old girls participating in at least one life skill session



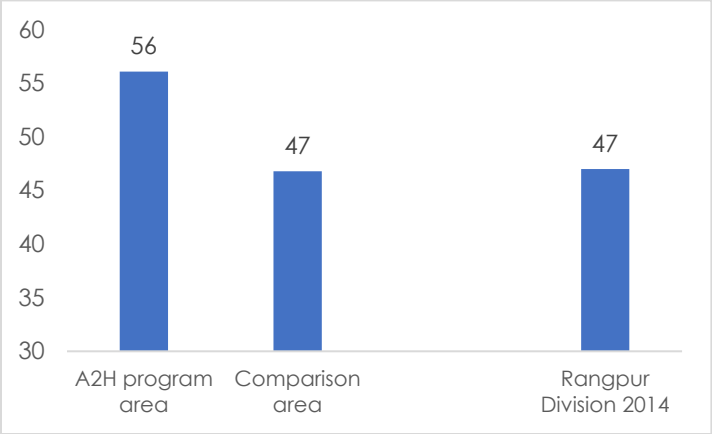
[2] Participation in the A2H program was determined by asking survey respondents: "Did you participate in the A2H life skills education sessions?"

- Among those who attended any session, only 17% of unmarried girls and 9% of married girls attended the program's complete eight sessions, the rest dropped out from the program before attending the required number of sessions.
- The most cited reason for dropping out from sessions was the lack of regularity of session timings compounded by the short notice of sessions. Inconvenient session timing was an issue for school-going adolescents. The low level of participation among married girls was associated with their busy household chores and needing parents-in-law's permission. Some girls reported distance as a reason for session discontinuation.
- Older girls were less likely to participate than younger ones. Among unmarried girls, those from poorer households were more likely to participate than those from relatively richer households. But among married girls, the pattern was the opposite—richer girls tended to have higher participation.
- The supportive environment created by the orientation of parents, guardians, and community-influential persons, and the acceptance of locally recruited CFs by the community, were important enabling factors for adolescents to attend life skills sessions.

Objective 1. Delay age at marriage

- Knowledge about legal age at marriage was nearly universal among adolescents irrespective of program participation and area of residence. Preferred age of marriage at 18 years or later was also universal for unmarried 15-19 year-old girls in A2H and comparison areas.
- The percentage of 15-19 year-old girls reporting preferred age of marriage at 20 years or later was higher in the A2H areas than in the comparison area (82% vs. 70%, respectively). More than half of adolescents (53%) in A2H areas felt highly confident that their parents would support marriage at age 20 or later compared to 37% in the comparison area. About 44% of unmarried girls (ages 15-19 years) in A2H areas, regardless of their participation in skill sessions, were confident that they could negotiate and change their parents' preference towards a later age of marriage if their parents preferred an earlier age than the girl's own preference, compared to 29% in the comparison area.
- About 56% of 15-19 year-old girls were never married in the A2H areas compared to 47% in the comparison area in 2018 (Figure 2). In 2014, 47% of 15-19 year-old girls were never married in Rangpur Division (NIPORT, 2016).
- Qualitative data suggest that unmarried girls and boys (ages 15-19 years) did take actions to delay marriages. The activities that they engaged in to delay marriages were negotiations with parents, guardians, influential community members, and the local government. These actions were successful in several cases. Three-out-of-ten girls participating in IDIs reported that they postponed four marriages in total including their own. Two-out-of-ten participating boys reported in IDIs that they helped postpone two marriages.
- The A2H program recorded about 250 marriages, regardless of program participation, that were postponed during the project period.

Figure 2. Percentage of 15-19 years old girls who were never married in 2018



Note on Figure 2: Data on marital status come from the household roster of the 2018 A2H survey in the program and comparison areas (Nahar, et al., 2020), and data for Rangpur Division come from the 2014 Bangladesh Demographic and Health Survey (NIPORT, et al., 2016). The difference in the percentage of never married between A2H program and comparison areas was statistically significant ($p<0.05$).

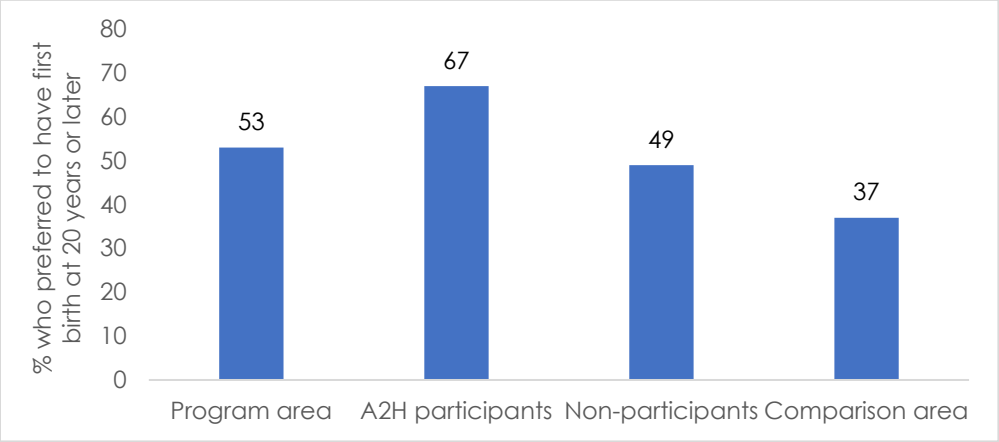
Selected qualitative findings: The project effect on marriage postponement

The participant adolescents began the process of negotiation with their parents and guardians, took assistance from the community facilitators and peers, and engaged the community-influential persons to postpone their marriages. In some cases, adolescents involved the local government institutions and related personnel and sought help even from the office of the local government chief executive. The idea of postponement of too-early marriages, and how it can be done, diffused among those adolescents living in the program areas who did not participate in the A2H program. With some initial examples of marriage postponements, it turned into a community mobilization, and subsequently had a ripple effect on delayed age of marriage.

Objective 2. Delay first birth and space between the first and second births

- Knowledge of at least three modern family planning (FP) methods and knowledge of at least one source of FP methods were almost universal among adolescent girls (married, unmarried, participants, and non-participants) in the program and comparison areas.
- Participation in the A2H program increased unmarried adolescent girls' confidence in the discussion and use of contraception in the future. Three-quarters of unmarried adolescent girls (ages 15-19 years) living in the program areas were highly confident about discussing family planning with their husband in the future compared to 69% in the comparison area.
- Contraceptive use was high among married 15-19 year-old girls, at 65% in both A2H and comparison areas.
- A notably higher proportion (67%) of married girls who participated in A2H sessions and who never gave birth or were currently not pregnant preferred to postpone childbearing to age 20 or older, compared to 49% of married non-participants living in the A2H program areas and 37% of those living in the comparison area (Figure 3).
- Preference for spacing of two or more years was high among married female adolescents who had at least one living child. Almost all married respondents who had at least one living child during the survey preferred birth spacing of 2+ years (97%). There was a similar picture in both program and comparison areas.

Figure 3. Among married girls ages 15-19 years, who never gave birth or are not currently pregnant, the percentage who want to postpone childbearing to age 20 years or older



Objective 3. Improve adolescents' SRH behavior

- There were no differences in knowledge, attitude, and practices about menstruation, perceptions about gender norms, and perceptions about measures to be taken to address sexual harassment, if they experience it, between participants and non-participants in the A2H program and comparison areas, implying that the A2H program may have had no effect on these issues.
- The level of healthcare seeking was similar among participants and non-participants in the program and comparison areas. The use of government facilities in the A2H program areas which were made adolescent friendly was low, and this was similar among the participants and non-participants (11% or less). The use of the same types of facilities (MCWC, UHC, UHFWC, or CC) in the comparison area was also low (<10%).
- Twenty-one health facilities were made adolescent friendly in the two program areas where the assessment was done; however, qualitative observation indicates weak demand-creation activities, lack of designated timetables for service delivery, and other issues affecting the use of health services by adolescents.

Discussion

The A2H interventions were mainly life skills training supplemented by strong community mobilization efforts that engaged adolescents, parents and in-laws, community influential people, and local government officials. Our assessment indicates that A2H had some influence on the incidence of early marriage and some of the other reproductive behaviors among 15-19 year-old girls. More complex and extensive interventions of the Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents (BALIKA) project during 2012-2015 have been found to reduce the likelihood of child marriage by 23-31% in Khulna Division, a south-western region (Amin, et al., 2018; The Population Council, 2020).

Implications

A2H added some of the best evidence on what works for reducing the incidence of early marriage in Bangladesh. The A2H program seems to have created a foundation for social change to tackle early marriage in Rangpur. Adolescents appear to have learned negotiation skills to engage their parents and guardians to achieve their preferred age at marriage. An A2H like program, with some modifications, has potential for reducing the incidence of teenage marriage in Bangladesh. Community mobilization through engagement of parents, guardians, and community-influential persons alongside activities with adolescents was the key to success.

The following are our recommendations for future interventions aimed at (a) delaying early marriage and improving reproductive behaviors, (b) adolescent-friendly health services (AFHS), and (c) the duration of future interventions:

Delaying early marriage and improving reproductive behaviors

- The number of life skills training sessions may be reduced to have maximum attendance in the program. The program should give emphasis on covering topics which have potential for improving knowledge and changing practice (e.g., menstrual hygiene).
- The sessions may be conducted at schools for those who are still in school (via after school sessions), and in the community for those who have dropped out of school. This strategy is likely to improve attendance at sessions by making them more convenient and thus increase the level of participation and decrease discontinuation. Sessions should be planned and participants notified well in advance.
- The knowledge about FP methods and their sources was universal among program participants, non-participants, and in the comparison area. This probably indicates that A2H had little scope to further improve FP knowledge. However, A2H efforts seemed to have increased confidence among unmarried girls about future FP use and negotiation skills. Birth spacing preference was similar in program and comparison areas and contraceptive use was already high (about 65%), suggesting that A2H interventions did not increase contraceptive use to promote birth spacing further. It is likely that there is high unmet need for family planning among 15-19 year-olds in A2H and comparison areas—nationally, unmet need for family planning was 15%

among 15-19 year-old girls in 2017-18; unmet need among females ages 15-49 years was 12% nationally (NIPORT & ICF, 2020). Fulfilling this high unmet need among 15-19 year-old girls requires more effective interventions which can be developed through a greater understanding of program barriers and challenges, for which further research is warranted.

Adolescent-friendly health services

- Investing in adolescent-friendly health services (AFHS) does not seem to be associated with increased use of services, and the use of health services generally is low among adolescents. The lack of improvement in AFHS utilization in the program areas may be associated with adolescents' and their parents' limited awareness about AFHS and existing health system weaknesses, as evident in the Population Council study (Ainul, et al., 2017). Attention should be given to increasing understanding of the health service needs of adolescents and the best ways to meet those needs.

Duration of future interventions

- The A2H program was a three-year program, yet the community was exposed to program interventions for only two years. This is a short period of time to affect changes in long-standing social norms and practices. Programs like A2H should be given sufficient program implementation time to see impacts on socially ingrained practices like delaying age at marriage or delaying birth.

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