Urban Adolescent Status Report

On sexual and reproductive health with a focus on family planning
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1. Objectives

The objectives of this report are to:

1) Consolidate and summarize all available information about urban adolescents' needs and practices related to family planning, using nationally representative survey data, and other published studies.
2) Map programs working on family planning with adolescents in urban areas across Bangladesh.

2. Introduction

BACKGROUND

UNFPA Bangladesh is undergoing a process of mainstreaming adolescent and youth issues across its thematic focus areas. These include sexual and reproductive health (SRH), gender, and population and development. To support this exercise, an examination of the situation of urban adolescents' sexual and reproductive health, focusing primarily on family planning, was undertaken. This status report summarizes the available literature on this topic. A mapping of agencies providing family planning information and services to urban adolescents in Bangladesh follows the literature summary.

URBAN ADOLESCENTS AND HEALTH: WHY INVEST?

In the past two decades, adolescents (young people between 10 and 19) have emerged as an increasingly important population group, more so than ever before. This is in part the result of an expanded body of knowledge of adolescents' specific health and development needs. It is also due to the recent growth of the largest proportion of adolescents and young adults, relative to other age groups, that has ever existed in history.

Bangladesh is currently undergoing a demographic transition. This occurs when a country's population moves from having high to low fertility and mortality rates, resulting in a bulge in the working age population relative to dependents. Bangladesh is expected to reap the economic benefits of its demographic transition between 2010 and 2040. Further, all future population growth is expected to be concentrated in urban areas. To maximize the economic benefit of the demographic dividend, the large workforce must be engaged in productive sectors. Further, the wealth generated must be invested productively. Therefore, there is a need for investment in human capital in the areas of health, education, employment opportunities and social services, particularly in urban areas, in order to maximize the capacities of the expanded workforce.

There are key factors that determine the well-being of adolescents and youth as they become adults. These include education, physical and mental health, gender equality, and the either accelerated or delayed transition to holding adult responsibilities. What happens during this time, in turn, directly influences the health of the next generation. This means that ensuring that more young people achieve their full potential has lifelong and intergenerational benefits. Moreover, doing so at this time increases the potential benefits of the demographic transition for Bangladesh overall in the years to come[1,2].

3. Summary of the Literature

OVERVIEW

Analysis of adolescent well-being typically entails exploration of trends across gender, age, and marital status differentials. Age disaggregated data are frequently broken down into the 10-14 (early adolescence) and 15-19 (late adolescence) age brackets. Analyses also look at whether adolescents are in or out of school and the concerns of disadvantaged and/or vulnerable groups. In Bangladesh, these groups include those with marginal living circumstances – such as adolescents who live in slums, in char or haor areas, in displaced persons camps, in detention facilities, or on the street. In addition, adolescents who have been trafficked, are engaged in child labor (including sex work), and who are living with disabilities are considered to be especially vulnerable[3].

This review focused first on nationally representative studies. Other, not nationally representative, but high-quality published studies were also reviewed. There is no comprehensive information available about adolescent boys (of any age) or unmarried adolescent girls. There is also very little information about 10-14 year old adolescent girls (whether married or unmarried), and out of school adolescents in general.

DATA SOURCES

The nationally representative studies reviewed include the Bangladesh Maternal Mortality and Healthcare Survey (BMMS) 2016ˆ, the Bangladesh Report on Sample Vital Statistics (SVS) 2016, the Violence Against Women Survey (VAW) 2016, the Bangladesh Demographic and Health Survey (BDHS) 2014, the Bangladesh Urban Health Survey 2013, and the BDHS 2011. These datasets have a range of valuable information about ever married females in the 15-19 age bracket.

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[1] Patton, G et al. (2016). Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet.* Vol 387
[2] Islam, M.M. (2016). Demographic transition in Bangladesh. *Journal of Population Research*. 33:283-305.
[3] National Strategy for Adolescent Health 2017-2030. *Ministry of Health and Family Welfare*.
ˆAt the time of writing, the BMMS 2016 was under technical review at the national level for validation of the survey findings. However, results were acceptable to reference in most relevant contextual analyses.

The non-nationally representative studies have somewhat more comprehensive information about certain populations (e.g., unmarried urban adolescent boys and girls, and married adolescent females living in slums). Certain topics (e.g., unintended pregnancy, condom use, and knowledge and use of contraception before marriage) are also covered in more detail.

WHERE ADOLESCENTS LIVE

Data from the 2016 SVS indicate that adolescents comprise 21.4% of the population. By 2021, it is expected that this will increase to above 22%. The proportion of adolescents in rural versus urban areas shifts slightly by gender during the adolescent years. In rural areas, the proportion of younger males and females, with respect to other age categories, is relatively equal. However, in the 15-19 age cohort, the proportion of rural males (with respect to the other age categories) is 1.7 percentage points higher than it is for rural females. This may be indicative of rural adolescent females moving to urban areas following marriage and/or to work in the garment industry.

By division, 10-19 year olds make up the largest proportion of the population in Sylhet, where they comprise 23.6%, and in Chattogram, where they comprise 23.4%. In Dhaka, adolescents comprise 21% of the population. Tables 1-7 display the raw numbers of adolescents living in each division in 2016, and what these numbers may look like in 2021, when the next cohort of children enters early adolescence. These estimates demonstrate that up to 55% of the adolescent population may live in Chattogram and Dhaka Divisions in the near future.

Adolescent Population Estimates for 2016 and 2021 by Division

Table 1. Barishal

Age	2016 Total Population: 9,145,000		2021 Total Population: 9,713,000	
10-14	11.7%	1,069,965	10.1%	981,013
15-19	9.7%	887,065	11.7%	1,136,421
10-19	**21.4%**	**1,957,030**	**21.8%**	**2,117,434**

Table 2. Chattogram

Age	2016 Total Population: 31,980,000		2021 Total Population: 34,747,000	
10-14	12.9%	4,125,420	11.6%	4,030,652
15-19	10.5%	3,357,900	12.9%	4,482,363
10-19	**23.4%**	**7,483,320**	**24.5%**	**8,513,015**

Table 3. Dhaka

Age	2016 Total Population: 52,539,000		2021 Total Population: 56,064,000	
10-14	11.6%	6,094,524	10.7%	5,998,848
15-19	9.4%	4,938,666	11.6%	6,503,424
10-19	**21.0%**	**11,033,190**	**22.3%**	**12,502,272**

Table 4. Khulna

Age	2016 Total Population: 17,252,000		2021 Total Population: 18,217,000	
10-14	10.4%	1,794,208	9.3%	1,694,181
15-19	9.1%	1,569,932	10.4%	1,894,568
10-19	**19.5%**	**3,364,140**	**19.7%**	**3,588,749**

Table 5. Rajshahi

Age	2016 Total Population: 20,412,000		2021 Total Population: 21,607,000	
10-14	10.4%	2,122,848	9.2%	1,987,844
15-19	9.0%	1,837,080	10.4%	2,247,128
10-19	**19.4%**	**3,959,928**	**19.6%**	**4,234,972**

Table 6. Rangpur

Age	2016 Total Population: 17,602,000		2021 Total Population: 18,868,000	
10-14	11.4%	2,006,628	10.0%	1,886,800
15-19	9.7%	1,707,394	11.4%	2,150,952
10-19	**21.1%**	**3,714,022**	**21.4%**	**4,037,752**

Table 7. Sylhet				
	2016		2021	
Age	Total Population: 11,291,000		Total Population: 12,463,000	
10-14	13.0%	1,467,830	11.7%	1,458,171
15-19	10.6%	1,196,846	13.0%	1,620,190
10-19	**23.6%**	**2,664,676**	**24.7%**	**3,078,361**

The percentages in these tables are sourced from the 2016 SVS report and the division population totals are sourced from the 2011 census population projections. The estimated populations of adolescents in 2016 versus 2021 reflect the proportional percentages of the population age groups for each division relative to the division population totals.

The 2016 estimates combine the SVS 10-14 and 15-19 age cohorts. To represent the future adolescent population, the 2021 estimates combine the 5-9 and 10-14 cohorts (i.e., the next cohort of adolescents). The actual numbers will also be affected by trends in fertility, mortality and migration.

Tables 8 and 9 display the overall country estimates in the same fashion as Tables 1-7, separating the urban and rural populations.

Adolescent Population Estimates for 2016 and 2021, Urban and Rural (All Bangladesh)

Table 8. Urban (All Bangladesh)				
	2016		2021	
Age	Total Population: 44,701,000		Total Population: 50,990,000	
10-14	11.1%	4,961,811	10.0%	5,099,000
15-19	9.7%	4,335,997	11.1%	5,659,890
10-19	**20.8%**	**9,297,808**	**21.1%**	**10,758,890**

Table 9. Rural (All Bangladesh)				
	2016		2021	
Age	Total Population: 115,518,000		Total Population: 120,694,000	
10-14	12.2%	14,093,196	10.7%	12,914,258
15-19	9.8%	11,320,764	12.2%	14,724,668
10-19	**22.0%**	**25,413,960**	**22.9%**	**27,638,926**

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: KEY FINDINGS

Despite the aforementioned data limitations, there is much information about married female adolescents. Review of all sources of data yielded the following key findings:

- Adolescent females have high rates of marriage, pregnancy and childbearing, with negative health consequences for themselves and their children
- Significant proportions of married adolescents and adolescent mothers would have preferred to marry and begin childbearing later than they did
- Adolescent females' unmet need for contraception is greater than that of adult females
- Most adolescents with an unmet need for contraception wish to space, rather than limit, births

- Adolescents have inadequate knowledge about family planning and about sexual and reproductive health issues more broadly
- Married adolescent females are somewhat less empowered than adult females, which is associated with lower contraceptive use and lower quality maternity care

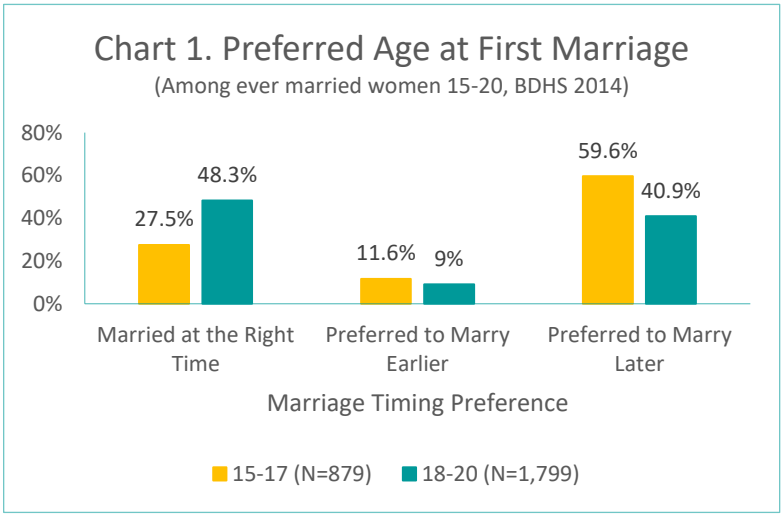
The key statistics and trends on which these findings are based follow.

I. Marriage

Adolescent Marriage Statistics

- 18.9% of urban girls 15-19 are married[5]
- 58.3% of married women 20-24 were married by age 18[4]
- 16.3% of married women 15-19 were married by age 15[4]

Though marriage age is increasing, marriage happens during adolescence for over half of adolescent girls. Boys marry about seven years later than girls, most of the time after reaching adulthood. Both girls and young men marry slightly over 1.5 years later in urban areas than in rural areas[5].



The 2013 Urban Health Survey reported a median marriage age among women 20-49 of 16.1 in City Corporation slums, 17.4 in City Corporation non-slums, and 16.4 in other urban areas[6]. The 2014 BDHS reported a median marriage age of 16.1 among all women (urban and rural) 20-49. Finally, the 2016 SVS reported a median age at first marriage of 18 among all females 10-45+[4,5].

Education (especially) and wealth are positively correlated with a later age at first marriage. Among married 15-17 year old girls, 59.6% would have preferred to marry later (Chart 1). There is a clear trend toward younger married women preferring to have married later[4]. This is

[4] Bangladesh Demographic and Health Survey 2014. (2016). *NIPORT, Mitra and Associates, DHS Program.*
[5] Report on Bangladesh Sample Vital Statistics 2016. (2017). *Bangladesh Bureau of Statistics.*
[6] Bangladesh Urban Health Survey 2013. *NIPORT, icddr,b, MEASURE Evaluation*.

supported by information reported in studies of urban adolescents and adolescents living in slums in the Dhaka Metropolitan Area[7,8].

In the 2014 BDHS, initiation of sexual activity among married women maps closely to figures on marriage. The data indicate virtually no premarital sex among women. However, it is also considered to have a potential for bias as unmarried women were not asked about their sexual activity. Further, married women may be unwilling to disclose information about premarital sex.

Indeed, other data sources indicate that premarital sexual activity does occur during adolescence for a small proportion of the general population, and among vulnerable groups (e.g., street children and sex workers)[7,9,10,11,12]. Data from a 2004 survey found that, among 1,048 unmarried urban and rural boys aged 15-19, 12.8% had reported ever having sex. Boys' sexual activity involved unprotected sex with sex workers. Having sex was associated with peer influence, while not having sex was associated with having future study plans and respect for parents' values and beliefs about sex[13].

Another study of 100,000 pregnancies over the period 1982-98 used data from the Matlab Health and Demographic Surveillance System (MHDSS) to examine abortion (defined to include menstrual regulation) rates among adolescents. The study found an average annual ratio of 29.3 abortions for every 1,000 pregnancies among adolescents, and 24.2 among adults. Abortion was more common among unmarried adolescents than among unmarried adults. Further, it was 35 times higher for unmarried than for married adolescents[14].

These findings indicate that sexual activity does occur before and/or outside of marriage among both adolescent boys and girls.

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[7] Amin et al. (2015). Urban Adolescents Needs Assessment Survey in Bangladesh. *BIED, BRACU, and Population Council*.

[8] Cortez, R et al. (2014). Knowledge Brief, Adolescent Sexual and Reproductive Health in Dhaka's Slums, Bangladesh. *World Bank Group.*

[9] Global School-based Student Health Survey, Bangladesh (2014).

[10] Uddin, J et al. (2014). Vulnerability of Bangladeshi street-children to HIV/AIDS: a qualitative study. *BMC Public Health,* 14:1151.

[11] Stavropoulou, M et al. (2017). Adolescent girls' capabilities in Bangladesh, The state of the evidence. *Gender and Adolescence: Global Evidence.*

[12] Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs 2015-2016. (2016). *National AIDS/STD Control Programme, Save the Children, UNAIDS*.

[13] Li, N., Boulay, M. (2010). Individual, familial and extra-familial factors associated with premarital sex among Bangladeshi male adolescents. *Sexual Health*, 7(4): 471-7.

[14] Ahmed, M.K., et al. (2005). Factors associated with adolescent abortion in a rural area of Bangladesh. *Tropical Medicine and International Health,* 10(2): 198-205.

II. Childbearing

Adolescent Fertility Statistics

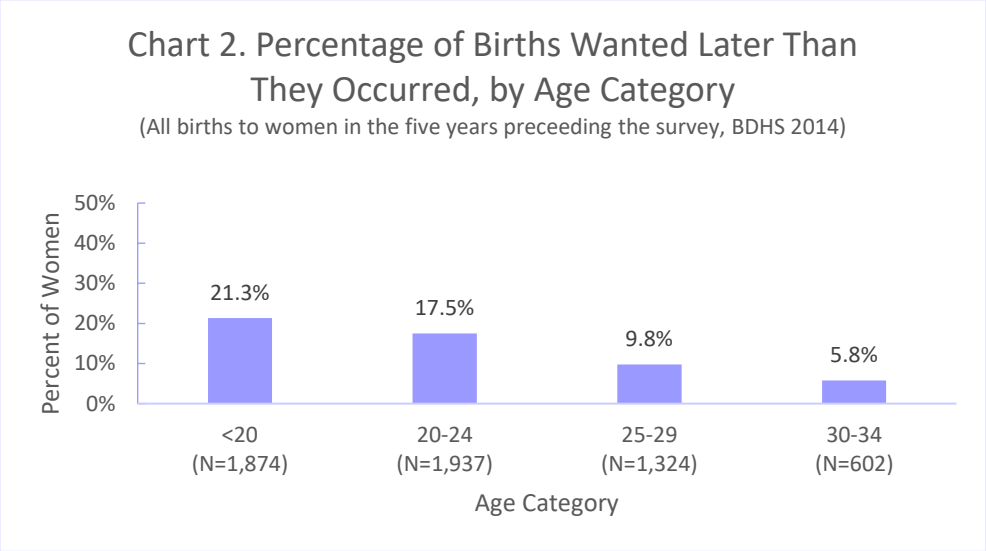
- 44% of 19 year old girls living in slums have begun childbearing[6]
- 58% of 19 year old girls nationwide have begun childbearing[4]
- 21.3% of births to 15-19 year olds were wanted later[4]

Childbearing during adolescence is slowly declining. However, as demonstrated by the first two statistics above, the reported percentages differ significantly between the Urban Health Survey and the BDHS. The Urban Health Survey reported that 21.4% of adolescent girls 15-19 in City Corporation slums had begun childbearing, whereas 13.3% had in City Corporation non-slums, and 19.5% had in other urban areas[6]. The BDHS reported that in urban areas, a higher 27% of adolescent girls had begun childbearing, compared to 32% in rural areas.

Nationally, the BDHS reported that 31% of adolescents 15-19 had begun childbearing, down from 33% in 2007. The prevalence of adolescent childbearing varies dramatically by division. In the BDHS, the highest percentage (37%) was found in both Rajshahi and Rangpur. In Dhaka, it was 32%, while the lowest (24%) was found in Sylhet[4].

Adolescent fertility rates also differ between the 2014 BDHS and the 2013 Urban Health Survey. The BDHS reports an adolescent fertility rate of 113 (98 urban, 120 rural), while the Urban Health Survey reported lower adolescent fertility rates of 84 in City Corporation slums, 56 in City Corporation non-slums and 75 in other urban areas.

Adolescent females' ideal is to have two children. The ideal number of children increases with age to 2.5 among 45-49 year olds. Education and wealth are positively correlated with later childbearing. BDHS data indicate that adolescents are more likely to have preferred to bear children later than are women of any other age category (Chart 2)[4]. While the proportion of births wanted later was lower in the Urban Health Survey than in the BDHS across most age categories, it was still higher among adolescents than among adult women[6].



III. Maternal and Newborn Health

Adolescent Maternal and Newborn Health Statistics

- 31.1% of ever married 15-19 year olds are undernourished[4]
- Adolescents are less knowledgeable about maternal complications than adult women[15]
- About 2/3 of pregnant adolescents receive antenatal care (ANC) from a medically trained provider (though in slums, a lower 54% do)ˆ[4,6,15]
- Yet, over 60% deliver at home, and less than 50% deliver with a medically trained provider (whether in a health facility or at home)[4,15]
- Adolescents <15 are less likely to receive skilled antenatal and delivery care than older adolescents and pregnant women in their 20s and 30s[15]
- Perinatal, neonatal, infant and under-5 mortality are higher among mothers <20 than among mothers 20-29[4]

Overall, adolescents enter pregnancy with greater risks, receive less and lower quality medical care, and have more adverse outcomes than adult women[4,16]. In addition, malnutrition is widespread among adolescent girls. This increases their risk of complications during delivery and of having a low birth weight baby. Various studies indicate an undernutrition prevalence that is close to 1/3 of both urban and rural adolescent females[11].

Data from the 2016 BMMS demonstrates lower levels of knowledge about maternal complications (e.g., pre-eclampsia symptoms, obstructed labor, heavy bleeding etc.) among pregnant adolescents' in comparison to adult women. Whereas 43% of 15-19 year olds had knowledge of the symptoms of pre-eclampsia, more than 47% of older women did. Similarly, 30% of 15-19 year olds knew about obstructed or prolonged labor, while 32% of 20-24 year

[15] Bangladesh Maternal Mortality Survey 2016. *NIPORT, icddr,b, MEASURE Evaluation.*
ˆDoctor, nurse, midwife, paramedic, SACMO, FWV, CSBA
[16] Context of Child Marriage and Its Implications in Bangladesh. (2017). *Dhaka University.*

olds, 37% of 25-29 year olds, and 36% of those over 30 did. Only 13% of 15-19 year olds had knowledge of severe or heavy bleeding as a pregnancy complication, while more than 18% of adult women did. Adolescents were also less knowledgeable than adult women about complications such as having a retained placenta, a high fever with smelly discharge and convulsions[15].

Regarding antenatal care, the 2016 BMMS found that, as compared to mothers in the 20-34 age bracket, pregnant adolescents were slightly less likely to have blood or urine samples taken during ANC visits. They are also more likely to deliver at home. Further, fewer than 40% of women who deliver under age 15 do so with a medically trained provider. However, there is no difference in the percentage of 15-19 year olds who deliver with a medically trained provider, as compared to women 20-34[15].

The data indicate that there may be a difference in the maternal mortality ratio among adolescents as compared to adults under 30. The latest SVS reported higher maternal mortality among adolescents as compared to women 20-30, while the latest BMMS reported a ratio slightly lowerˆ. However, between the 2010 BMMS and the 2016 BMMS, maternal mortality among 15-19 year olds increased dramatically, from .49 to 1.34 maternal deaths per 1,000 live births. Meanwhile, a study of 42,214 pregnant women in rural northwest Bangladesh found that women <18 and >35 had an increased risk of obstetric complications, a finding that is supported in the global literature[17,18].

Box 1: Perinatal and Early Childhood Mortality Definitions

Perinatal Mortality: deaths caused by pregnancy losses occurring after seven completed months of gestation (stillbirths) and those deaths within the first seven days of life (early neonatal deaths).
Neonatal mortality: the probability of dying within the first month of life.
Post-neonatal mortality: the difference between infant and neonatal mortality.
Infant mortality: the probability of dying before the first birthday.
Child mortality: the probability of dying between the first and fifth birthday.
Under-5 mortality: the probability of dying between birth and the fifth birthday.

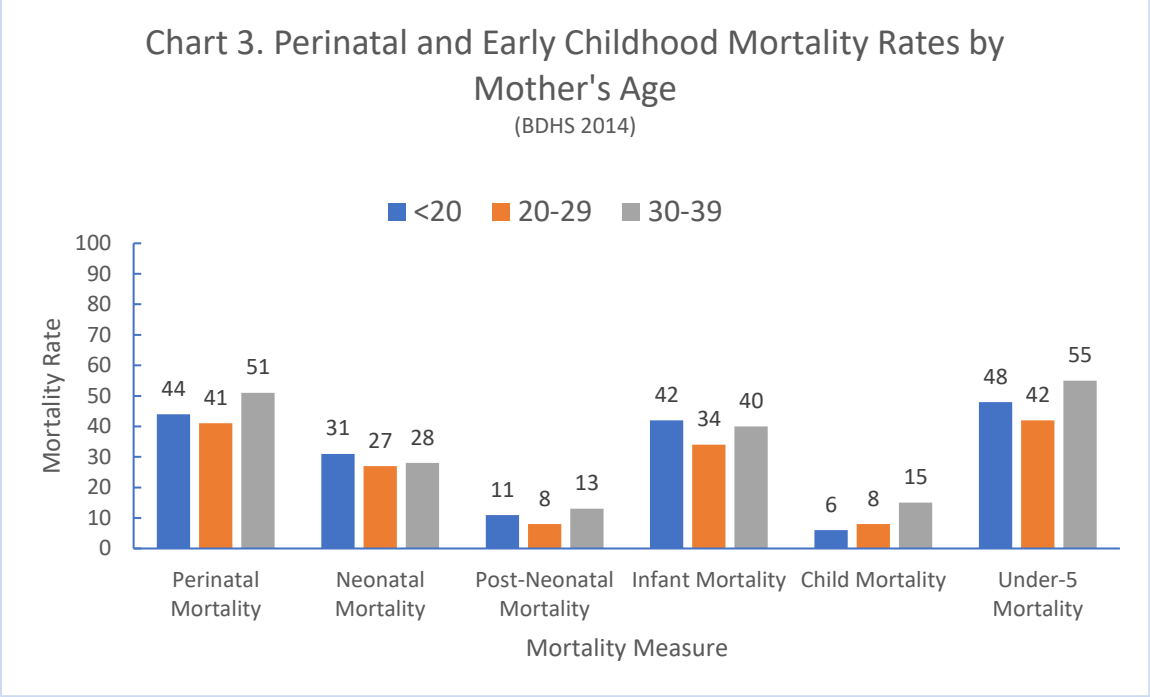
Source: BDHS 2014

Following delivery, adolescents receive postnatal care at about the same rate as women 20-34[4,15]. However, perinatal, neonatal, post-neonatal, infant and under-5 mortality are higher among mothers <20 than among mothers 20-29 (Chart 3, see Box 1 above for definitions). In

[17] Sikder, S.S. et al. (2014). Risk factors for reported obstetric complications and near misses in rural northwest Bangladesh: analysis from a prospective cohort study. *BMC Pregnancy and Childbirth,* 14:347.
[18] Santhya, K.G. (2011). Early marriage and sexual reproductive health vulnerabilities of young women: a synthesis of recent evidence from developing countries. *Current Opinion in Obstetrics and Gynecology*. 23(5): 334-339.
ˆThe MMRs reported in the 2016 SVS were: 2.06 (15-19yrs), 1.45 (20-24yrs), 1.65 (25-29yrs), and 1.27 (30-34yrs). The MMRs reported in the 2016 BMMS were: 1.34 (15-19yrs), 1.36 (20-24yrs), 1.76 (25-29yrs), 3.83 (30-34yrs). The Demographic and Health Surveys Program recommends always using national vital statistics over surveys for determining the most reliable maternal mortality ratio: https://blog.dhsprogram.com/mmr-prmr/.

contrast, child mortality, a measure of the probability of dying between the first and fifth birthday, was lowest among adolescents compared to the other age groups (20-29 and 30-39)[4].

In both the SVS and BDHS, these mortality rates were generally higher in rural areas, with minor exceptions. The SVS reported a small urban-rural difference in neonatal mortality (20 neonatal deaths per 1,000 live births in urban areas versus 19 in rural areas). In contrast, the BDHS reported a large difference (21 in urban areas versus 31 in rural areas). Similarly, the SVS reported a small urban-rural difference in post-neonatal mortality (8 in urban areas versus 9 in rural areas), whereas the BDHS reported a higher post-neonatal mortality in urban areas (13 in urban areas compared to 9 in rural areas).

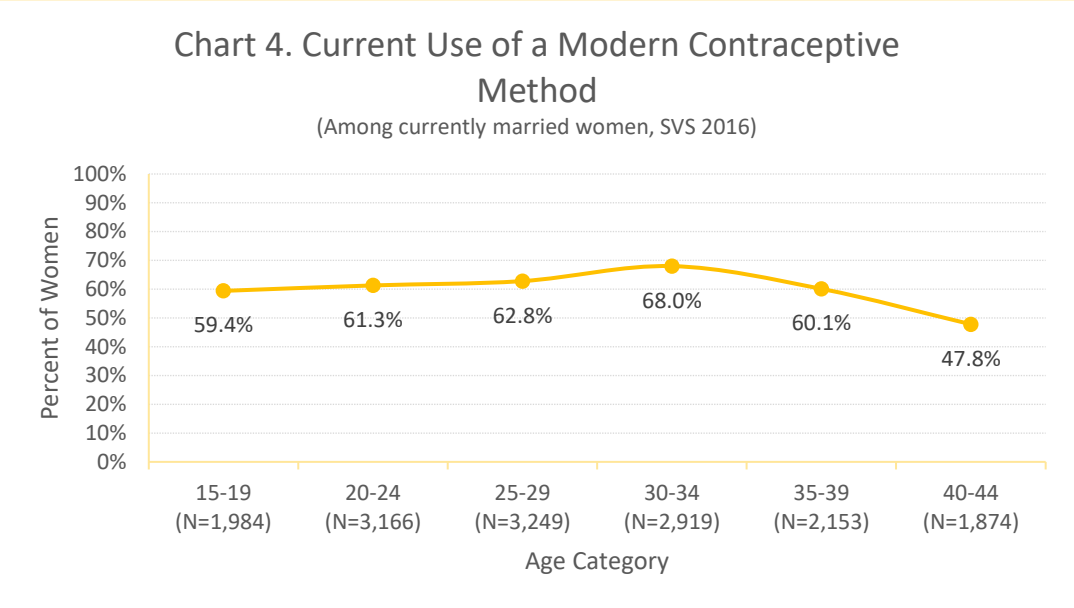


IV. Family Planning

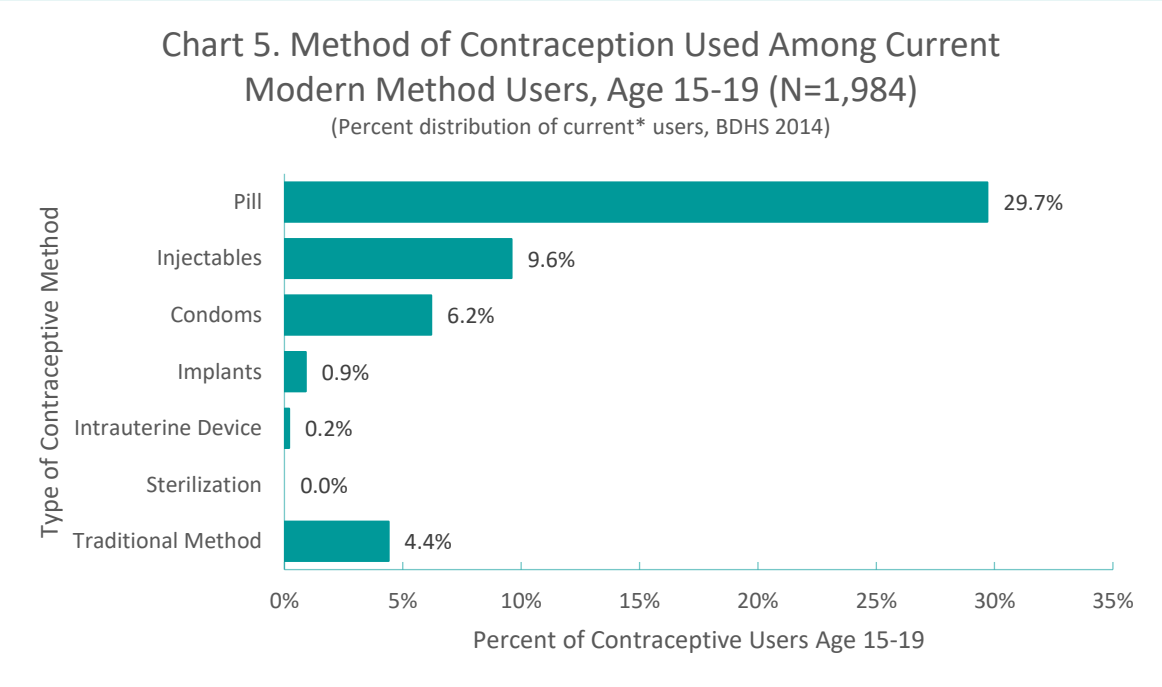
Adolescent Family Planning Statistics

- 59% of married adolescents use a modern method of contraception[5]
- 17.1% have an unmet need for family planning, with most desiring greater birth spacing[4]
- 49.7% of 15-29 year olds would choose the birth control pill for their future method of contraception, 20.1% would choose an injectable contraceptive, and 21.7% are unsure which method they would choose[4]

As shown in Chart 4, the 2016 SVS reported that 59.4% of married adolescents were current users of a modern contraceptive method. This statistic generally corresponds to that reported in other studies[6,7,8], though the 2014 BDHS reported a lower 46.7% modern contraceptive use rate among ever married adolescents. For comparison, the modern contraceptive prevalence among 15-49 year olds was 58.4% in the SVS and 54.1% in the BDHS. Though the modern contraceptive prevalence in the SVS was higher for all age groups than it was in the BDHS, both studies show a consistent pattern of increasing contraceptive prevalence by age cohort, with a peak in the 30-34 age group, followed by a decline.



The birth control pill is the most commonly used method of contraception among females (Chart 5), followed by injectable contraceptives and condoms. In one study, 77% of ever married urban adolescent boys had used a condom. This study also reported that close to 18% had used the safe period. Contraceptive use among unmarried urban adolescent boys was less than 2% and was 2.1% among unmarried urban adolescent girls[7]. Older women are more likely than adolescents to use a traditional method of contraception. Across all ages, women living in urban areas are more likely to use a modern method of contraception than women in rural areas[4].



There is fairly widespread knowledge about family planning methods, in particular the birth control pill[4,5,8]. Knowledge about contraception appears to be better among married adolescents than among their unmarried peers[7]. However, this knowledge may not be comprehensive[8,19]. The existing research reveals that both urban and rural adolescents generally enter married life with inadequate knowledge of contraception (e.g., the range of options available, where to obtain them, how to use them etc.), as well as sexual and reproductive health issues more broadly (e.g., menstruation, sexually transmitted infections, menstrual regulation, the consequences of child marriage etc.)[7,11,15,19,20,21].

While there is only limited information available in nationally representative datasets to further substantiate this, the information that is available on sexual and reproductive health knowledge levels among adolescents corroborates it. One example is pregnant adolescents' lower levels of knowledge about maternal complications discussed in section III[15]. Another is married adolescents' lower levels of knowledge about menstrual regulation discussed at the end of this section[4]. A third is ever married adolescent females' relatively low, and possibly declining, levels

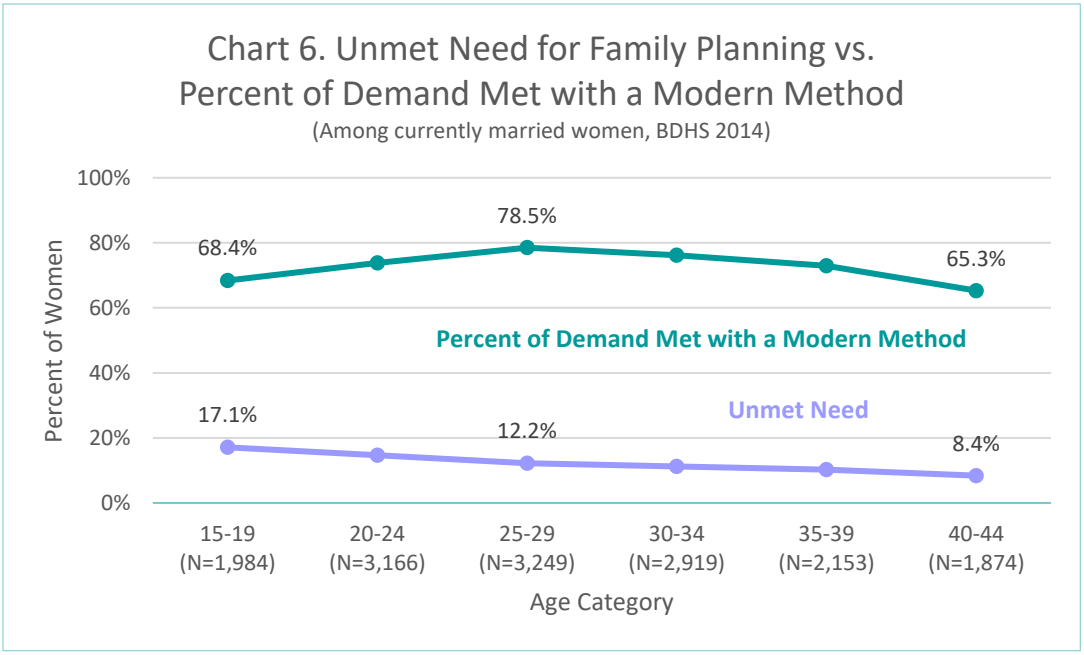
[19] Huda, F. et al. (2014). Prevalence of unintended pregnancy and needs for family planning among married adolescent girls living in urban slums of Dhaka, Bangladesh. *Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP).*

[20] Reeuwijk, M., Nahar, P. (2013). The importance of a positive approach to sexuality in sexual health programmes for unmarried adolescents in Bangladesh. *Reproductive Health Matters*, 21:41, 69-77.

[21] Choudary, S.R., Rahman, M., (2012). Status of Female Adolescents Living at Rajshahi Slum in Bangladesh. *Bangladesh Journal of Medical Science*, 14(1).

of knowledge about HIV/AIDS topics. For example, the 2014 BDHS reports that while 72% of ever married adolescent girls had heard of AIDS, only 12% had comprehensive knowledge of AIDS. Further, the 2011 BDHS reported that a higher 75% of ever married adolescent girls had heard of AIDS, and while 47% of ever married adolescent girls knew that condom use prevents HIV transmission in 2011, a lower 42% did in 2014. A similar decline in knowledge was measured from the 2011 BDHS to the 2014 BDHS on knowledge of whether limiting sexual intercourse to one uninfected partner prevents HIV transmission (56% of ever married 15-19 year olds in 2011 versus 52% in 2014)[4,22].

Married adolescents have a higher unmet need for family planning than any other age group (Chart 6). Chart 6 displays the trendlines for 1) unmet need for contraception, and 2) the percent of demand for contraception that is met with a modern method. Adolescents have a higher unmet need and a lower level of met demand for a modern method than adults 20-34. Unmet need for contraception is greater in rural areas than in urban areas[4].

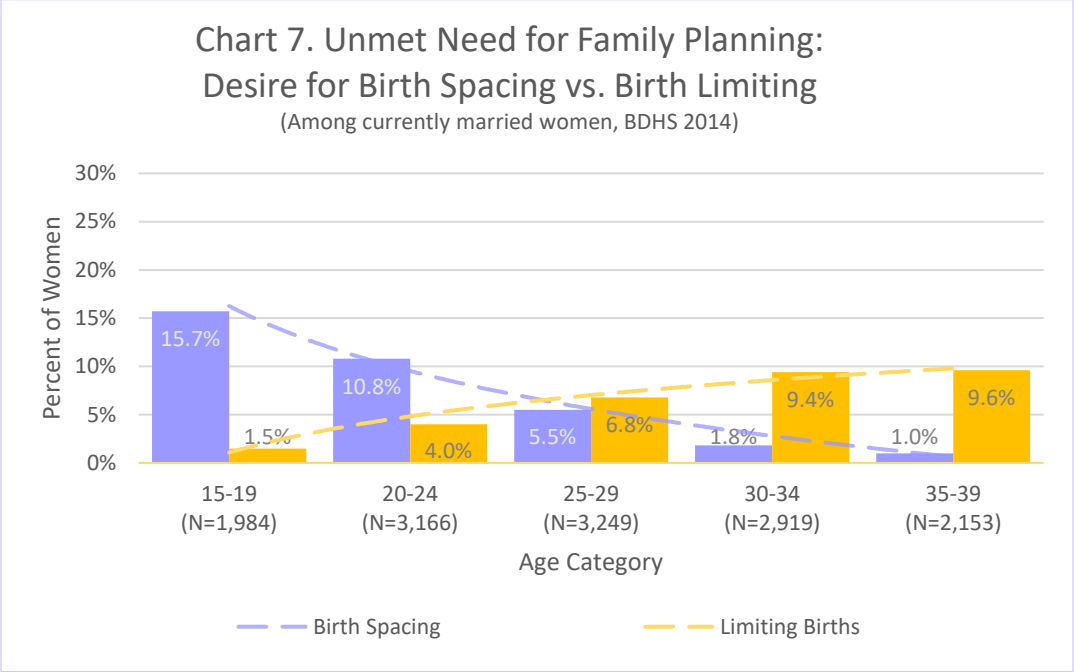


Regarding unmet need for contraception, a study of 1,008 married adolescents living in Dhaka slums found a 53% prevalence of unintended pregnancy. This study found that unintended pregnancies were largely due to improper use or non-use of family planning as a result of user-related factors[19].

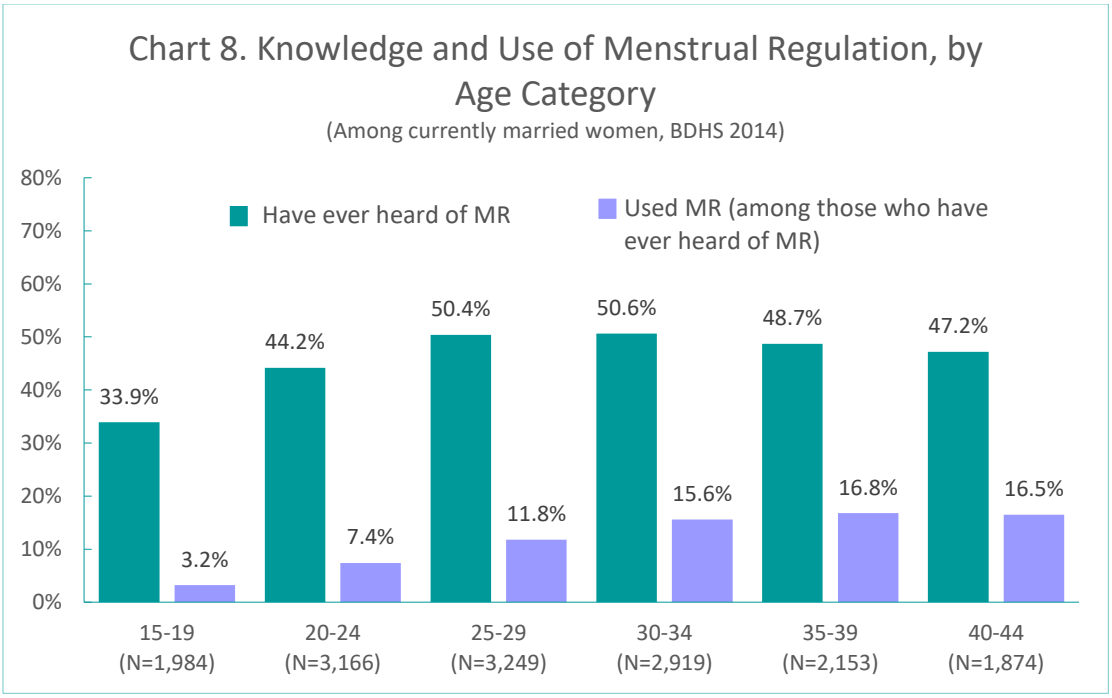
Among adolescents with unmet need for family planning, most desire to space, rather than limit, births (Chart 7). The 2014 BDHS reported that births are generally spaced far apart in

[22] Bangladesh Demographic and Health Survey 2011. (2012). *NIPORT, Mitra and Associates, MEASURE DHS.*

Bangladesh, with a median interval of 52 months. However, adolescents have the shortest period between births, with a median of 24 months between births.



Both knowledge and use of menstrual regulation (MR) are lower among adolescents than among adult women (Chart 8). Evidence indicates that knowledge among unmarried adolescents is lower than among married adolescents, and that there is stigma associated with the practice[4,14]. Notwithstanding, the earlier referenced analysis of MHDSS data of 100,000 pregnancies over the period 1982-1998 found that the abortion ratio (which includes MR) among unmarried adolescents was 35 times higher than it was for married adolescents. Data on the use of the emergency contraceptive pill (ECP) among adolescents is not readily available. However, across all ages, both knowledge and use of ECP are higher in urban areas, and more women are aware of MR than they are of ECP[4].



VI. Harmful Gender Norms and Reproductive Health

Statistics on Violence, Harassment, and Decision Making Among Adolescents

- 43% of adolescent girls have experienced either physical or sexual violence by a partner[23]
- 28.8% of ever married adolescent girls believe wife beating is acceptable for at least one specific reason[4]
- Sexual harassment of adolescent girls, known as "eve teasing," is common and related to socio-cultural norms around sexuality[24]
- Fewer adolescents make household decisions by themselves or with their husbands compared to older women[4]

It is common for adolescent females to experience violence perpetrated by both partners and non-partners. The 2015 VAW survey reported that 28% of adolescent females had experienced either physical or sexual violence perpetrated by their partners within the last 12 months, and 43% had at some point in their lifetime. While these percentages are lower than those for adult women, physical violence perpetrated by non-partners was higher among adolescent females (11%) than among adult women (percentages ranged from 4.7%-6.4% across adult age cohorts). The VAW survey reported relatively low levels of sexual violence perpetrated by non-partners (2%-4% across all age categories)[23].

[23] Report on Violence Against Women (VAW) Survey 2015. (2016). *Bangladesh Bureau of Statistics.*

Significant numbers of married adolescent females believe that spousal abuse is acceptable. One study among adolescent girls living in Dhaka slums reported that fewer than 30% believed it was justified for a husband to beat his wife if she went out without telling him. A higher 35% believed that it was acceptable for a husband to beat his wife if she did not take care of the house or the children. Fifty-five percent believed it was acceptable if a wife showed disrespect toward her in-laws[8].

One qualitative study analyzed the phenomenon of "eve teasing," through focus group discussions with 237 unmarried adolescent girls, and in depth interviews with 15 adolescent girls and 16 adolescent boys. Eve teasing refers to the sexual harassment of adolescent girls by boys. This study found that for boys, eve teasing is a mode of experiencing sexual pleasure and demonstrating their masculinity. Most boys who engaged in it did so because they enjoyed it and had not considered how girls might feel about it. Girls disliked eve teasing, sharing that it provoked insecurity. They described feeling that they would be blamed for it. The study authors assert that eve teasing is a result of restrictions on social interactions between the sexes and is exacerbated by pornographic media and a lack of sexuality education. They further argue that these forces impede the development of competence in sexual interaction. This lack of competence may then undermine possibilities for mutually rewarding sexual encounters[24].

Women's participation in household decision making, an indicator of empowerment, was explored in the 2014 BDHS. The findings indicate a lower level of joint husband-wife decision making among adolescents than among married adults. Yet, while adolescent females were slightly more likely to make decisions about their earnings on their own than older women, it was also more common for their husbands to make decisions on their own about their wife's earnings than it was for older couples[4].

BDHS data also show that women's participation in household decisions has a positive bearing on contraceptive use. However, the relationship between beliefs about wife beating and contraceptive use is unclear.

4. Mapping

The following table displays the results from the mapping. Projects were included if they had a specific focus on family planning (either education/awareness raising or service provision) and engaged in targeted activities to reach urban adolescents. Sixteen projects were identified using these criteria. Multiple projects that work generally on sexual and reproductive health with adolescents and/or early marriage prevention, but that do not have a specific, or comprehensive, focus on family planning, were excluded.

[24] Nahar, P. et al. (2013). Contextualising sexual harassment of adolescent girls in Bangladesh. *Reproductive Health Matters*.

#	Project Name	Implementing Organizations	Funders	Dates	Adolescent Target Population	Urban Geographic Focus	Program Summary	Scale	Evaluation Activities
1	Acceptance, Valuing, Information, Zero Tolerance, Advocacy, and Networking (AVIZAN) Towards Youth and Women's Empowerment	FPAB	IPPF	1980 - present	Adolescents and Youth 10-24 (including transgender adolescents)	Dhaka, Chattogram, Barishal, Cumilla, Cox's Bazar, Dinajpur, Faridpur, Jamalpur, Kushita, Patuakhali, Rangamati, Tangail, Jessore, Khulna, Rangpur and Sylhet	FPAB works to promote sexual and reproductive health of young people with particular emphasis on enabling access to comprehensive, youth friendly, gender sensitive sexuality education and services (including LARC) for adolescents and young adult women. Operates 25 static clinics and 45 mobile teams. It also works on young people's participation in governance, programs, advocacy and community mobilization. Sensitizes community members together with parents and community leaders. Also conducts teacher trainings on SRH based on national curriculum.	Nation-wide, 5 million people (53% adolescents and youth)	Various (have a youth research team)
2	Addressing Unmet Need of SRHR for Young People Through Creating Awareness	RHSTEP	Swedish Association for Sexuality Education (RFSU)	2010-2018	Adolescents and Youth 10-24	Khulna and Sylhet	Provide FP education (including LARC) and counseling to adolescents and youth at two Alordhara centers via male and female counselors. FP services available through Adolescent Corner at Khulna Medical College Hospital. Teacher training on FP/SRHR in govt. schools and madrassas with joint govt. monitoring of school health sessions. Project also creates community support groups.	--	--
3	Adolescent and School Health Program, 4th Health, Population and Nutrition Sector Program (2017-2022)	MOH&FW (implemented through DGHS)	GoB, WB, GFF, DFID, GAC, SIDA, EKN	2017-2022	Adolescents in school	National, with focus on Chattogram and Sylhet	Introduction of a school-based health care package for adolescents covering SRHR (inclusive of FP), nutrition, mental health and violence. Dedicated coordination within schools, supported through the Ministry of Education. Also, extension of outreach from health facilities to schools, combined with steps to ensure greater adolescent responsiveness in health care facilities, particularly at the union and community levels.	Goal of 30% of all public schools by 2022 (roll out to madrassas and private schools after public schools)	Baseline, midline and endline evaluations
4	Adolescent Development Program	BRAC	SPA, UNICEF, Women Win and British Council	2016-2020	Adolescents 10-19	**Dhaka**: Shyamoli, Mirpur, Uttarkhan, Uttara, Badda, Bonosree, Jatrabari, South Badda, Narayangonj and Tongi. **Chittagong**: Pachlaish, Kazir Dewry Bondor, Chatgaon, Mohora, Jalalabad, Bakulia, Kornofuli. **Rajshahi**: Rajshahi Sadar. **Khulna**: Shiromoni, Khalishpur, Borisal. **Sylhet**: Sylhet Sadar.	BRAC Adolescent Development programme supports adolescent clubs that offer life skill based education, both indoor & outdoor sports, cultural activities, mini library, and comprehensive sexual and reproductive health education (including on family planning methods).	5,705 clubs reaching 199,675 adolescents	--
5	Adolescent Friendly Health Services Program, 4th Health, Population and Nutrition Sector Program (2017-2022)	MOH&FW (implemented through DGFP with UNICEF, UNFPA, Save the Children, Plan International, and RHSTEP)	GoB, USAID, EU, SIDA, EKN	2017-2022	Adolescents 10-19	National	Establishment of adolescent friendly health services (AFHS) within existing district level MCWCs and UH&FWCs. Services cover general health issues, SRHR/FP (provision of full range of contraceptives for married adolescents; provision of only counseling for unmarried adolescents). Facilities are renovated to enable adolescents to be seen in an area that is separated from general patients, and to receive audio-visual privacy during consultations. Services are documented in an adolescent health services register. Service providers receive training on adolescent friendly health services.	403 AFHS centers already established; goal of total of 979 AFHS centers by 2022	Various, through partners
6	Adolescent Health & Rights Enhancement Through Innovation and System Strengthening (ADOHEARTS)	UNICEF (with MOHFW - DGFP & DGHS - MoE, MOWCA, BSMMU, OGSB, UNFPA, BPA, and Dutch supported NGOs)	EKN	2016-2020	Adolescents 10-19	Dhaka City Corporation + Jamalpur, Tangail, Gazipur, and Khulna Districts	Establishing AFHS at different levels of facilities, operations research on AFHS, integration of adolescent health indicators (including on FP counseling) into HMIS, support for development of national level adolescent skills framework, and development of 1) national costed plan of action for Adolescent Health Strategy 2017-2030, 2) adolescent health SBCC strategy, 3) short course on adolescent health (by BSMMU), 4) accreditation guidelines for AFHS, and 5) national and sub-national adolescent health coordination committees. Currently support two AFHS locations in Dhaka: Mohammadpur Fertility Service and Training center (MFSTC) and OGSB Hospital in Mirpur	National	Baseline evaluation conducted, operations research and other evaluation activities planned
7	Advancing Adolescent Health (A2H)	Plan Bangladesh (with ESDO & Lamb Hospital)	USAID	2016-2019 (possible 2yr extension)	Adolescents 10-19 (Marginalized groups: dalits, indigenous, socially excluded, orphans)	Rangpur District (project covers both urban and rural areas in the mostly rural district)	Education sessions on FP with adolescents 10-14 and 15-19, boys and girls (separate), led by trained facilitators employed by project. Follow-up done by peers to link adolescents to services. Married adolescent community sales agents trained by the project and linked to Social Marketing Company provide birth control pills, nutrition supplements and condoms to other adolescents in the community. Married adolescent couples are registered and receive orientation session. Training and upgrading of government health facilities at the sub district level to become adolescent friendly. Teacher training on SRHR to build teachers' confidence in delivering content on sexual health. Awareness raising among parents and community gatekeepers.	All upazilas in Rangpur: 295,000 adolescents Specific targeting of +/- 10,000 married adolescent couples to delay first birth and do birth spacing	MEASURE Evaluation doing KAP survey Introduction of an "AFHS Community Score Card"
8	Advancing Universal Health Coverage (AUHC) Activity	Chemonics International Inc. (in partnership with PSI, ThinkWell LLC, Ad-din, Green Delta)	USAID	2017-2022	Adolescents 10-19	189 urban clinics around the country	Provision of Essential Services Package, including FP counseling and short-acting methods. Also outreach to schools and communities for adolescents to share information about healthy timing and spacing of pregnancy.	Forty million service contacts per year. Number of adolescents served through this project over 1 year will be available in September 2018.	Various research and evaluation activities are part of this project; currently none are focused on adolescents.
9	Creating an Enabling Environment for Young People to Claim and Access their Sexual and Reproductive Health Rights in Bangladesh	Plan Bangladesh (with SAP Bangladesh, YPSA and Marie Stopes)	EU, SIDA	2015-2019	Adolescents and Youth 10-24 (Marginalized groups: poor, ethnic minorities, those living in haor areas)	Khagrachhari, Kishoreganj, Barguna	Provide education and mobilization around comprehensive sexuality education through community based peer to peer approach. Establish youth clubs and forums and Adolescent Friendly Health Services (including FP) through three Maternal and Child Welfare Centers. Registration of newly married adolescent couples. Also provide referrals and linkages to FP services as well as FP commodities through satellite services.	200,000 young people 10-24 (including 12,000 newly married young people and 20,000 newly pregnant women and girls)	Baseline, midline and endline evaluations and study, *Programme effectiveness trial on sexual and reproductive health and rights in three rural districts of Bangladesh: A qualitative exploration*

#	Project Name	Implementing Organizations	Funders	Dates	Adolescent Target Population	Urban Geographic Focus	Program Summary	Scale	Evaluation Activities
10	Family Planning in Bangladesh - Ensuring Quality and Coverage	Ipas (with RHSTEP, BAPSA, BNNRC, VARD & BASA)	UKaid	2017-2022	Adolescents 15-19	Cities: Dhaka, Chattogram, Sylhet, Rajshahi, Rangpur and Barishal Small urban areas: Sreemongal, Chattak, Patuakhali, Kalapari, Shokhipur, Ghatail, Ramu, Chokoria	Introducing and/or strengthening services for FP (including LARC), MR and PAC in DGHS hospitals and private health centers, from which they are currently lacking (either not available or limited). Special focus on adolescents: provider training on confidential counseling and values transformation vis-à-vis adolescent service provision, and exit interviews with adolescents following receipt of services. There is also a community access component in smaller urban areas that focuses on family planning with adolescents.	Nation-wide (only urban areas)	Tracking % of user population that is 15-19
11	Improving the Health and Nutrition Status of the Extreme Urban Poor	Concern Worldwide (with BRAC)	EU	2016-2019	Adolescents 10-19	Dhaka North and South, Chattogram City Corporation, Mymensingh Municipality	Distributes vouchers to extreme poor to access health services at existing service points. Coordinates works with MOLGRD and through other service delivery partners. Training partners to fullfill project mandate to provide youth friendly services, including FP, at all service points. Also organizing a campaign to bring adolescents to services and providing health kits to adolescents that include sanitary napkins, iron suplements, vit. A, and other items.	Total target population: 878,000 extreme poor (including 90,164 adolescent girls)	Examination of adolescent service utilization rates
12	Improving SRHR Situation through Comprehensive Sexuality Education Among Adolescents and Youth in Selected Areas of Bangladesh	BAPSA	RFSU	2014-2018	Adolescents 10-19, (mainly unmarried)	Dhaka North	SRHR training (including FP) for adolescents through a youth friendly services center. Center has 1 male counselor and 1 female counselor. FP services are provided on the same premisis through a BAPSA clinic. Project also engages in advocacy at community level and with MoE, DGFP, and DGHS and trains teachers to improve their competence in delivering SRHR content in classrooms.	3,665 adolescents/youth since 2014	Baseline, midline and endline evaluations
13	Manoshi	BRAC	DFID and DFAT (BRAC SPA fund)	2016-2020	Adolescents 10-19	City Corporations - Dhaka (North and South), Narayangonj, Cumilla, Chattogram, Sylhet, Rajshasi, Barisal, Khulna and Gazipur + Mymensingh municipality area.	BRAC runs 45 urban health centers (23 of these are in Dhaka slums). LARC and short acting methods are provided in the centers, and short acting methods are also provided door to door through community workers.	110,982 adolescents are covered in Dhaka North and South City Corporations. Reached 57,693 married adolescents in 2017.	--
14	Promoting Sustainable Health and Nutrition Opportunities for the Marginalized Urban Extreme Poor Population (PROSHOMON) in Bangladesh	Concern Worldwide (with Sajida Foundation)	EU	2018-2021	Adolescents 10-19	Chandpur and Feni Municipalities (Chattogram)	Distributes vouchers to extreme poor to access health services at existing service points. Coordinates work with MOLGRD and through other service delivery partners. Training partners to fullfill project mandate to provide youth friendly services, including FP, at all service points. Also organizing a campaign to bring adolescents to services and providing health kits to adolescents that include sanitary napkins, iron suplements, vit. A, and other items.	Total target population: 40,763 extreme poor (including 4,507 adolescent girls)	Examination of adolescent service utilization rates
15	Safe MR Project: Strengthening of Safe Menstrual Regulation and Family Planning Services and Reduction of Unsafe Abortions	RHSTEP and BAPSA	SIDA	2017-2021	Adolescents 10-19	Dhaka, Chattogram, Mymensingh, Rangpur, Barishal, Sylhet, Rajshahi, Khulna, Cumilla, Faridpur, Bogura, Pabna, Narail, Cox's Bazar, Dinajpur + Hill Tract Sadars: Rangamati, Bandarban and Khagrachhari	Provide MR and FP (including LARC) services, and raise awareness in schools and communities at 22 service centers located in public medical college hospitals and district hospitals.	Reach 0.6 million individuals annually (about 1/3 are adolescents)	• *Effectiveness of SRH education among adolescents: A school based intervention study in Dhaka city* • Client exit interview studies every six months • Pilot study with OGSB on menstrual regulation with medication
16	Unite for Body Rights II	RHSTEP (with BAPSA, PSTC, DSK, BNPS, FPAB, BANDHU, BRAC-IED, Naripokkho, Rutgers and SIMAVI)	EKN	2016-2019	Adolescents 10-19 (in and out of school)	Cities: Chattogram, Mymensingh Urban Areas: Gazipur and Savar Semi Urban Areas: Pabna, Noakhali, Rajasthali, Kawkhali, Kaptai and Rangamati Sadar	Provide teacher training on SRHR based on govt. approved text books plus the supplemental 'Me and My World' comprehensive sexuality education curriculum and provide FP services through youth friendly health centers for married and unmarried adolescents and youth (adolescents are referred to govt. health facilities for LARC). Also engage in advocacy, including organizing youth forums (ages 10-24) with youth organizers. Plan to provide training for GoB service providers on youth friendly services.	200,000 adolescents	Baseline and endline evaluations + mid-term review
17	Urban Health: Strengthening Care for Poor Mothers and Newborns in Bangladesh	Marie Stopes	UKaid	2013-2018 (possible +3-5yrs)	Urban poor, including married and unmarried adolescents 15-19	Total of 52 urban centers in 40 districts	Provide family planning services, including LARC, through Marie Stopes clinics. Adolescents comprise about 7% of service users. Working to increase this through youth clubs attached to 16 urban clinics. Boys and girls participate in peer groups to generate adolescent clients. Service promoters/health educators also work to generate adolescent clients. Each clinic has an expert counsellor focused on motivating young clients. Newlywed couples and pregnant adolescents are targeted to receive information and service linkages for FP. The project has also developed flip charts and leaflets to support the delivery of SRH information, including FP, to young people.	Reach about 20,000 adolescents annually through the urban clinics	Tracking % of user population that is 15-19, with goal of increasing from 7% to 15%
18	Urban Primary Health Care Service Delivery Project Phase II (UPHCSDP II)	LGD, MOLGRD&C (with multiple NGOs)	ADB and GOB	2018-2023	Urban adolescents 10-19, including those living in poverty	National: city corporations and district municipalities. All areas from Phase I, plus new areas (list to be determined).	Primary healthcare services, including comprehensive FP. Special focus on adolescents to include ensuring adolescent friendly counseling on safe sex, prevention of RTIs/STIs, identification and treatment of ASRH problems, prevention of early marriage and gender issues for boys and girls. Also treatment for anemia and tetatus toxoid vaccination for adolescent girls. Will also conduct outreach targeted for adolescents and develop new educational materials.	Nation-wide (only urban areas)	Operations research, ongoing performance monitoring, midterm review and endline evaluation

5. Recommendations

A) GATHER MORE NATIONALLY REPRESENTATIVE DATA ON ADOLESCENTS

a) Conduct a National Adolescent and Youth Survey - There is a need for more easily accessible nationally representative data on adolescents' knowledge, attitudes and practices related to their sexual health and family planning. A National Adolescent and Youth Survey, like the one conducted in Nepal (published in 2011), should be considered[25]. This survey was designed to ensure representative data from boys and girls 10-14, 15-19 and 20-24 across various geographical divisions. Ideally, representative data from each of these age groups, with analyses conducted across various dimensions (e.g., gender, age, area of residence, marital status, in/out of school etc.) should be made available through this survey. Topics should cover a full range of family planning and sexual and reproductive topics, including knowledge, attitudes and behaviors.

b) Include More Data on Adolescents in the Next BDHS - It may be useful to explore opportunities during the early planning stage of the next BDHS to collect and report on more data on adolescents. This could include asking questions about adolescents' knowledge, attitudes and/or behaviors around family planning, sexual and reproductive health, and gender norms. Ideally, both adolescent boys and girls would be represented.

c) Develop a Separate BDHS Adolescent Report - A separate adolescent report based on future BDHS data, like the one published in Nepal in 2013, should also be considered. This report compared trends in data from 15-19 and 20-24 year olds across four previous NDHS surveys[26]. A report like this could help facilitate the sharing of findings relevant to the adolescent population for policy makers and program managers who work directly on adolescent health.

d) Conduct Qualitative Research - There is a need for exploratory qualitative research on adolescents' thoughts, feelings and behaviors related to sexuality and contraceptive decision making. Research organizations and non-governmental organizations may be well positioned to carry out such research. Well designed, in depth qualitative research can assist programs to deepen their understanding of prevalent beliefs and practices among different groups of adolescents, and who and

[25] Nepal Adolescent and Youth Survey 2010/2011. (2011). *Population Division, Ministry of Health and Population, Government of Nepal.*

[26] Khatiwada N. et al. Sexual and Reproductive Health of Adolescents and Youth in Nepal: Trends and Determinants, Further Analysis of the 2011 Nepal Demographic and Health Survey. (2013). *Calverton, Maryland, USA: Nepal Ministry of Health and Population, New ERA, and ICF International.*

what influence them. This would in turn enable more effective targeting of messages to unique sub-groups of adolescents (and potentially parents and/or community members) via audience segmentation.

e) **Engage with GAGE on its Longitudinal Study** - The Gender and Adolescence: Global Evidence (GAGE) project plans to conduct a mixed-methods longitudinal impact evaluation study. It will cover 18,000 adolescent boys and girls and their caregivers in Bangladesh, Ethiopia, Nepal and Rwanda. In addition to a quantitative survey, the project plans to conduct qualitative and participatory research to gather information on adolescents' various social influences. It may be useful to engage with GAGE during their planning and implementation process for this study.

B) EXPAND ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS

a) **Education on Family Planning** - The available data indicate clear opportunities to enhance educational opportunities for urban adolescents on sexual and reproductive health, including their family planning options, prior to the initiation of sexual activity. The aim of this would be to create opportunities for more adolescents to delay marriage and childbearing, thus increasing opportunities for girls to avoid the health consequences of early childbearing, stay in school longer, and engage more in productive work.

b) **Target Geographic "Hotspots"** - Program planners and managers should identify and target geographic 'hotspots' with concentrations of girls at risk of early marriage and pregnancy, and increase their levels of satisfied demand for family planning information and services.

c) **Adolescent Friendly Health Services** - Continue scaling-up and assessing the national initiative to establish adolescent friendly health services within existing public health facilities. Findings from assessments of this initiative should be rapidly integrated into current and future scale-up plans.