



NATIONAL STRATEGY FOR ADOLESCENT HEALTH 2017-2030



**Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh**

National Strategy for Adolescent Health 2017-2030
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NATIONAL STRATEGY FOR ADOLESCENT HEALTH 2017-2030



MCH Services Unit
Directorate General of Family Planning
Ministry of Health and Family Welfare



Executive Summary

Bangladesh has an adolescent population of approximately 36 million: more than one-fifth of the total population of Bangladesh is those between the ages of 10 and 19 years (BBS, 2015). This large cohort presents significant potential for the social and economic development of the country if we make the necessary investments to make them healthy and productive. It has been evidenced that investments in adolescent health can bring a triple dividends of immediate benefits, benefits into future adult life and benefits for the next generation of children (*Patton et al., 2016*). A strong strategy, which identifies key areas for investment, is essential if the overall health and wellbeing of adolescents is to be realized. This National Adolescent Health Strategy 2017-2030 was developed to address the overall health needs of adolescents by taking a broad and holistic understanding of the concept of health. It also fills a gap where adolescent health issues were not addressed comprehensively in other policy documents.

The National Adolescent Health Strategy 2017-2030 has been developed using a participatory process, with active participation and contributions from key stakeholder groups. Under the leadership of the Ministry of Health and Family Welfare and immediate guidance of the Directorate General of Family Planning, a core committee and several technical committees were established to provide expert input and ensure a comprehensive strategy document. The strategy development process included reviewing of existing national and international literature to assess current trends in adolescent health, conducting five divisional consultations with local level stakeholders, conducting four focus group discussions with adolescents, conducting meetings of the core committee and technical committees and organizing a two-day national workshop. The final draft of the strategy document was presented to the Inter-Ministerial Committee and finalized subsequent to incorporating their comments.

The National Adolescent Health Strategy 2017-2030 has identified four priority thematic areas of intervention: adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition and mental health of adolescents. In addition social and behavioural change communication and health systems strengthening are included as cross cutting issues, which need to be addressed for the effective implementation of the strategy. The management of the National Adolescent Health Strategy will require an effective management and coordination structure, which has been detailed in the final section of this strategy document. This document highlights the importance of all relevant actors in the development sector – both Government and Non-Government – working in collaboration with each other if the goal and vision of this strategy is to be realized during the given time period.

The National Adolescent Health Strategy 2017-2030 has been developed for a period of 14 years – from 2017 to 2030 – to be in line with the Sustainable Development Goals. The Strategy envisions that by 2030, all adolescents in Bangladesh will be able to enjoy a healthy life and has the goal of all adolescents attaining a healthy and productive life in a socially secure and supportive environment. This strategy is guided by human rights principles and clearly states that all adolescents, irrespective of their gender, age, class, caste, ethnicity, religion, disability, civil status, sexual orientation, geographic divide or HIV status, have the right to attain the highest standard of health. The Ministry of Health and Family Welfare is committed to ensuring the effective implementation of this strategy, which will contribute to the overall wellbeing and health of all adolescent boys and girls of Bangladesh.

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Mohammed Nasim, MP
Minister
Ministry of Health & Family Welfare
Govt. of the People's Republic of Bangladesh



মোহাম্মদ নাসিম, এমপি
মন্ত্রী
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার



Message

Adolescence is a crucial transitional phase of human development. This stage is characterized by physical, emotional and social changes that require understanding and effective approaches to meet the specific needs of adolescents. Today's adolescents experience an earlier onset of puberty and often have limited knowledge about their sexuality and the consequences of sexual behavior; have high risk of pregnancy and pregnancy complications; and are exposed early to sexually transmitted infections (STI).


Adolescents constitute more than one fifth of our population. While the government has been providing support to female education, child marriage and adolescent pregnancy undermine the wellbeing of girls and pose a challenge to the development of the country. The median age of marriage is still below the legal age of marriage for the girls in Bangladesh and there has been no significant increase observed in the median age of marriage in last two decades. Indeed, the contribution of the adolescent fertility rate to the total fertility rate has increased. Child marriage and adolescent pregnancy remain high, about one-third of adolescents beginning childbearing which results in health complications for themselves and for their children. Therefore, reducing child marriage/ adolescent pregnancy, limiting the frequency of births, increasing the birth interval/ birth spacing by adopting appropriate family planning methods and providing quality sexual and reproductive health services can have a crucial impact on the lives of adolescents and the next generation.

Bangladesh has made notable progress not only in child survival but also in the maternal health over the last decade. Despite this remarkable progress, we still have numerous challenges, which have to be addressed as we are committed to reduce child marriage and to ensure access to quality adolescent friendly health services.

Overcoming the current limitation in making available quality adolescent friendly health services and information will impact the overall development of all adolescents and ensuring them to reach full potential.

I want to congratulate the Directorate General of Family Planning and all stakeholders for developing a comprehensive national strategy for adolescent health and I am hopeful that all strategic issues will be addressed in next sector programme of the Ministry of Health and Family Welfare.

Joy Bangla, Joy Bangabandhu
Long live Bangladesh.


Mohammed Nasim
8/6/17

Zahid Maleque, MP
State Minister
Ministry of Health & Family Welfare
Govt. of the People's Republic of Bangladesh



জাহিদ মালেক, এমপি
প্রতিমন্ত্রী
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার



Message

Adolescents constitute more than one-fifth of our population. They are the most vibrant, promising and innovative group in society. However, they need to be given a solid education, information and healthcare to ensure their future development. Bangladesh will be in a position to reap a demographic dividend if we invest in and provide proper support to our adolescents to become competent citizens of our country. Along with other ministries, the Ministry of Health and Family Welfare is working relentlessly to improve the health status of adolescents in the country.

Child marriage and adolescent pregnancy is the most pressing adolescent health problem in Bangladesh. According to Bangladesh Demographic and Health Survey, 2014 fifty nine percent of women, aged 20-24 years, were married before the age of 18 years and 31 percent of 15-19 year old adolescents have begun child bearing. The adolescent fertility rate, among those aged 15-19 years, is 113 live births per 1000 women and this is the highest rate in South Asia. The honourable Prime Minister Sheikh Hasina pledged to end child marriage under 15 years by 2021, and end all marriage before age 18 by 2041, at the London Girl Summit in 2014. The government has developed a National Plan of Action to stop child marriage in Bangladesh and also amended the Child Marriage Restraint Law.

The Directorate General of Family Planning (DGFP) with the support of UNFPA developed Adolescent Reproductive Health Strategy in 2006, which has now been revised to cover all adolescent health issues through this new strategy document. I would like to congratulate the DGFP along with UNFPA, UNICEF and WHO for following through the process of developing a comprehensive strategy for adolescent health by addressing key issues such as adolescent sexual and reproductive health, violence, mental health and nutrition among adolescents. I hope this strategy will provide an opportunity for all relevant ministries to adopt a coordinated approach to meet the health need of adolescents.

Joy Bangla, Joy Bangabandhu
Long live Bangladesh.

Zahid Maleque
(Zahid Maleque, MP)

MD. SIRAZUL ISLAM
Secretary

Medical Education & Family Welfare Division
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh



মোঃ সিরাজুল ইসলাম
সচিব
স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার



Message

In Bangladesh more than one fifth of the total population is adolescents. Ensuring the health of all adolescents, therefore, is crucial for both global and national development. The health sector of Bangladesh has recognized the importance of addressing this issue, keeping in line the country's commitment to meet the SDGs by 2030. Though Bangladesh has shown significant progress in maternal and child health and family planning areas, adolescent health is yet to be fully addressed, despite this significant population in the country.

Adolescents face many preventable or treatable health problems such as unwanted pregnancies, pregnancy related complications, sexually transmitted infections, HIV/AIDS, lower respiratory tract infections, abuse/violence and suicide. Half of all mental health disorders in adulthood appear to start during early adolescence, mostly as a result of early warning signs being undetected and untreated. Adolescents become vulnerable due to the lack of knowledge and skills such as sexual and reproductive health, life skills, protective and legal measures and related services. They have limited access to facilities and opportunities which can make them healthy and productive citizen of this country.

Currently, the Ministry of Health and Family Welfare (MoH&FW) has been implementing adolescent-friendly health services through two wings – the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). This National Adolescent Health Strategy, 2017-2030, replaces the previous National Adolescent Sexual and Reproductive Health Strategy developed by DGFP and UNFPA in 2006, and ensures a more holistic approach by focusing on the overall health needs of adolescents.

I would like to appreciate and thank DGFP for taking the initiative and UNFPA, UNICEF and WHO for providing both technical and financial support to this timely and crucial endeavor of developing the National Adolescent Health Strategy 2017-2030. This strategy will build a momentum on evidence-informed priority setting to achieve universal access to Sexual and Reproductive Health and Rights under the framework of Sustainable Development Goals and beyond.

Md. Sirazul Islam



Secretary
Health Services Division
Ministry of Health & Family Welfare
Govt. of People's Republic of Bangladesh

Message

Adolescence is a transitional period between child and adulthood of human life with gross biological, psychological, mental and social changes that occur simultaneously but at a different pace for each adolescent. These changes depend on her/ his gender, socio-economic background, education and exposure to various other structural and environmental factors. Biologically adolescents experience pubertal changes and changes in brain structure and psychologically they develop cognitive and thinking skills. They also experience social changes with multiple roles as they are expected to play in the family, community and at school. So, adolescents' health and wellbeing is an important issue for overall development of the country.

Adolescent girls face gender-based discrimination, evident in the practice of child marriage, the high rates of adolescent fertility, the high prevalence of domestic violence, the increasing incidence of sexual abuse and higher drop-out rates from secondary education due to the patriarchal social norms of Bangladesh. Adolescent boys face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviors such as unsafe sex, violence and substance abuse.

Effective Adolescent-friendly health services demands multi-sectorial participation and coordination; because, health problems of adolescents are linked and influenced by many social, non-health and multi-factorial issues. With this realization, 'adolescent health' becomes 'adolescent health and development' to widen the spectrum towards comprehensive services for adolescents. Following the human rights approach, AFHS should ensure adolescents' involvement in decisions and actions as the actors for social change, not simply beneficiaries of programs.

I would like to thank Directorate General of Family Planning to take initiative for development of the National Adolescent Health Strategy, 2017-2030 and also to UN agencies especially UNFPA, WHO and UNICEF for supports on its completion process. I am hopeful that all Development Partners and UN agencies and concerned stakeholders will work together with MOHFW to address the needs of adolescents with a special emphasis on their health issues based on this strategy.


Md. Serajul Huq Khan



Message

Dr. Kazi Mustafa Sarwar
Director General
Directorate General of Family Planning

Adolescence is a period of rapid development when major physical changes take place and differences between boys and girls are accentuated through pubertal changes. As a substantial component of the total population (22.4%), they are the future asset of the country. Therefore, we have to emphasize on the healthy and productive development of our adolescents. Their reproductive health needs differ greatly with age, sex and marital status. As they reach adulthood, their attitude, behaviour, and practices concerning gender, health and life opportunities become crucial.

Adolescents face several health risks due to child marriage and early child bearing, under nutrition, violence, drug use, STI/RTI and HIV/AIDS, inadequate education, discriminatory gender norms and taboos, poverty etc. According to the Bangladesh Demographic and Health Survey 2014, the median age at first marriage for women is 17.2 years; 31 percent of 15-19 years old girls have begun childbearing; more than 64 percent of the same age group received antenatal care from medically trained persons and 36 percent had facility delivery. Modern contraceptives are being used by about 47% of 15-19 year old married girls and 17 percent have an unmet need for family planning. The current adolescent fertility rate is 113 live births per 1000 women of 15-19 years age. The children of adolescent mothers are more likely to be of low birth weight and stunted (BMMS 2010).

The Ministry of Health and Family Welfare of Bangladesh has shown farsightedness in developing the National Adolescent Health Strategy, 2017-2030, which will create the necessary policy and legal environment to promote adolescent sexual and reproductive health and development. This strategy has covered many health issues in addition to sexual and reproductive health, and includes mental health, nutrition, violence, social and behaviour change communication (SBBC) and rights which have a strong influence over adolescent health. Given the difficult situation faced by most adolescents, MCH services unit of Directorate General of Family Planning, with support from UNFPA and UNICEF, and other international organizations, has started to provide adolescent-friendly health services at district and union levels. I hope through this initiative we will be able to ensure the health of adolescents as detailed in the Sustainable Development Goals, by 2030.

I would like to express my sincere gratitude to UNFPA, UNICEF and WHO for their support in developing the National Adolescent Health Strategy, 2017-2030 by extending their co-operation towards adolescent health and development. I must congratulate the MCH-Services unit of DGFP for taking timely initiative to develop this strategy. I request all Development Partners and UN agencies to work with the MOHFW to address the needs of adolescents with a special emphasis on their health issues. I believe this strategy will direct us in ensuring the effective, context-specific and feasible implementation of all adolescent health related interventions in HPN sector programmes.

Dr. Kazi Mustafa Sarwar



Message

Professor Dr. Abul Kalam Azad
Director General
Directorate General of Health Services

Bangladesh has made significant improvements in the health and family planning sector in the last few decades. Being a large and growing segment of the population, adolescents need information, counseling, services and other support to ensure their development. Historically, adolescents' health needs have been neglected based on the assumption that they will remain physically strong during this transition period. Given the importance of shaping the country's future development and the importance of adolescent health in ensuring this, Government of the People's Republic of Bangladesh has been working at different levels of health facilities, not only to improve maternal and child health but also to improve adolescent health.

The country's current adolescent population is approximately 36 million, which is more than the total population of many countries. In Bangladesh, adolescents face many challenges as they are physically, mentally and socially vulnerable. They become victims of child marriage, early and unwanted pregnancy, abuse, under nutrition etc. - which expose them to life threatening risks and then, to death. Those who survive, live with chronic morbidities, leading to the perpetuation of a cycle of intergenerational poverty. Child marriage and adolescent pregnancy increases the risk of maternal and child morbidity and mortality along with other problems. These challenging issues need to be addressed if the adolescents of Bangladesh are to grow up to be healthy and productive adults who will in the future present Bangladesh as a prosperous nation and country to the whole world.

I would like to congratulate the MCH services unit of the Directorate General of Family Planning under Ministry of Health and Family Welfare for taking this timely initiative when the first HPN Sector programme of SDG era in Bangladesh is being started. I would like to thank our Development Partners - UNFPA, UNICEF and WHO for coming forward with their support to us. I also would like to thank colleagues from other Line Ministries, civil society partners and experts who work in different areas of adolescent health and supported the development of this strategy. I firmly believe that the National Adolescent Health Strategy 2017-2030 will be useful for our adolescents as well as for all policymakers and service providers of our country.

Professor Dr. Abul Kalam Azad

Message from UNFPA, UNICEF and WHO

Adolescence is the period when an individual has to deal with significant physical, mental and emotional changes as they begin the transit from childhood to adulthood. Given the vulnerability of this life stage, it is crucial to ensure that adolescents are given the necessary services, information, skills and opportunities, to develop their full potential to become productive, healthy and peace-loving adults. Investing in the health of adolescents, including their sexual and reproductive health, is also essential if a country is to capitalize on the demographic window of opportunity presented by the adolescent population cohort and reap the benefits of a demographic dividend.

Bangladesh currently has more than one fifth of its total population consisting of adolescents. The proportion of adolescents in the population is expected to grow in the coming years, making it imperative for us to invest in their overall health and wellbeing. Not only the sheer size of this young population cohort, but also the public health, economic and human rights drivers necessitate investment in the health and development of adolescents at this time. Investing in adolescent health will bring the triple dividend: benefit adolescents now, benefit them in the future and also benefit the next generation.

The Government of Bangladesh is committed to ensuring the health of adolescents and making adolescents aware of the significance of practicing healthy habits from a very young age. The National Adolescent Health Strategy 2017-2030, developed under the leadership of the Ministry of Health and Family Welfare, with support from UNFPA, UNICEF and WHO and in collaboration with other key partners in the development sector, including adolescent groups, is a strong statement by the Government of Bangladesh on the importance it attaches to meeting the health needs of this critical population cohort.

In 2016, UN member states including Bangladesh unanimously embarked on the joint journey of achieving the Sustainable Development Goals (SDGs) building on the progress made by the Millennium Development Goals. In this era of SDGs, this initiative to develop the National Adolescent Health Strategy (NAHS) is both timely and vital. Following the time-line of the SDGs as well as the Global Strategy for Women's, Children's and Adolescents' Health, the NAHS will highlight the necessary strategic directions and identify investments needed to provide a healthy transition for all adolescents of Bangladesh by 2030.

We in UNFPA, UNICEF and WHO hereby commit to support the implementation of this strategy and its action plan by providing technical assistance to the Government of Bangladesh to, ensure evidence based interventions, maintain the quality of care and strengthen the health system to guarantee the wellbeing and development of adolescents. We are of the conviction that this strategy will provide the necessary guidance and underscore the directions that need to be taken by both Government and non-government actors to meet the health needs of all adolescents of Bangladesh.



Iori Kato
UNFPA Representative, a.i.



N. Paranietharan
WHO Representative



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UNICEF Representative





Dr. Mohammed Sharif
Director (MCH- Services) & Line Director (MCRAH)
Directorate General of Family Planning

Acknowledgement

Bangladesh has experienced a dramatic decline in fertility and mortality over the last decade. Our Honorable Prime Minister Sheikh Hasina has been acknowledged globally and awarded by the United Nations for these tremendous achievements made by the country. Declining fertility and mortality has produced a significant shift in the age structure of the population, with more people in working age groups than in dependent age groups. This has created a window of economic opportunity that can be seen as a demographic dividend for Bangladesh. The demographic dividend is unlikely to last long, as has been observed earlier in other countries. This dividend at present provides an opportunity for Bangladesh to make use of its working-age population for productive socio-economic activities.

To translate this opportunity into a reality, investments in adolescents from both public and private sectors are most critical. Through ensuring health and education, the Government needs to prepare adolescents for the future job market. To obtain full benefit of this demographic dividend, the Government needs to develop appropriate policies and program for adolescents.

The Ministry of Health and Family Welfare has recognized the needs of adolescents and led the Directorate General of Family Planning (DGFP) to develop the first National Strategy for Adolescent Sexual and Reproductive Health (ASRH) in 2006 with the support of the UNFPA. Under this strategy, the DGFP has been implementing Adolescent Friendly Health Services in 203 facilities of 14 districts, has formed the “Adolescent Sexual and Reproductive Networking Forum”, published an “Adolescent Health” newsletter, created a website for adolescents (www.adolescent-mchdgifpbd.org) and has developed IEC materials for adolescents. UNFPA, UNICEF, Plan International Bangladesh, Save the Children, Population Council, USAID and the Embassy of the Kingdom of the Netherlands have supported DGFP through these endeavors.

To align with the SDGs, the DGFP, under the leadership of the Ministry of Health and Family Welfare, has taken the initiative to revise the national strategy for ASRH of 2006 with the support of the DGHS, UNICEF, UNFPA and WHO.

The strategy was revised to be comprehensive and renamed as the “National Strategy for Adolescent Health 2017-2030” through incorporation of nutrition, mental health, substance abuse, violence and injury along with sexual and reproductive health with regards to adolescents. Other issues of adolescent health, such as child marriage, STI/RTI & HIV/AIDS, were also included in this comprehensive document.

A group of experts worked relentlessly through several meetings, workshops and focus group discussions involving different stakeholders, gatekeepers and adolescents. I want to express my sincere gratitude to these experts and also to the organizations involved in the development process of the strategy. I also want to express my heartfelt thanks to the MoHFW for their continuous support in arranging inter-ministerial meetings and for their kind approval of the final draft of the document. I would also like to express my gratitude to UNFPA, UNICEF and WHO for providing support in the process of developing the strategy.

I hope the strategy will direct our work to meet the health needs of adolescents in this country and that we will be able to work together to bring positive changes in their lives.



Dr. Mohammed Sharif
Director (MCH Services) & Line Director (MCRAH)
Directorate General of Family Planning

Abbreviations

AFHS	Adolescent Friendly Health Services
AHS	Adolescent Health Strategy
AIDS	Acquired Immune Deficiency Syndrome
ARHS	Adolescent Reproductive Health Strategy
ASRH	Adolescent Sexual & Reproductive Health
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BMI	Body Mass Index
BMMS	Bangladesh Maternal Mortality Survey
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
EmOC	Emergency Obstetric Care
ESP	Essential Service Package
FHI	Family Health International
FSNSP	Food Security Nutritional Surveillance Project
GBV	Gender Based Violence
HDRC	Human Development and Research Center
HIV	Human Immunodeficiency Virus
HKI	Hellen Keller International
HMIS	Health Management Information System
ICDDRB	International Center for Diarrheal Disease Research, Bangladesh
ICRW	International Center for Research on Women
IFA	Iron Folic Acid
JPGSPH	James P Grant School of Public Health
MARA	Most At Risk Adolescents
MCH	Maternal and Child Health
MCWC	Mother & Child Welfare Center
MMS	Multiple Micronutrient Supplementation
MoHFW	Ministry of Health & Family Welfare
NAHS	National Adolescent Health Strategy
NASP	National AIDS and STD Program
NGO	Non-government Organization

RD	Rural Dispensary
RTI	Reproductive Tract Infection
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TT	Tetanus Toxoid
UH&FWC	Union Health and Family Welfare Center
UHC	Upazilla Health Complex
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UPHCSDP	Urban Primary Health Care Service Delivery Project
VAW	Violence Against Women
WHO	World Health Organization

1.1. Defining Adolescence

Adolescence, a near universal life stage of the socialization process, is defined as a period of human growth and development that occurs after childhood and before adulthood and, according to the UN, includes those persons between 10 and 19 years of age (WHO 2014). Adolescence is a time of transition involving multi-dimensional changes: biological, psychological, mental and social (UNICEF, 2006). Biologically, adolescents experience pubertal changes and changes in brain structure. Psychologically and mentally, adolescents' cognitive capacities mature and they develop critical thinking skills. Adolescents also experience social change as a result of the multiple roles they are expected to play in the family, community and at school. These changes occur simultaneously but at a different pace for each adolescent depending on her/his gender, socio-economic background, education and exposure to various other structural and environmental factors (UNICEF, 2006). As a developmental phase in human life, adolescence is further divided into early adolescence (10-14 years) and late adolescence (15-19 years). An understanding of these sub-stages of development during adolescence is important from the perspective of policy planning as well as designing and implementing adolescent related programmes.

1.2. Adolescents in Bangladesh

Bangladesh has a significant adolescent population. In 2011, more than one-fifth (20.5 percent) of the total population, that is 30.68 million, were adolescents (BBS, 2011) and according to population projections, both the percentage and absolute number of adolescents will continue to increase until 2021 (UNFPA 2015). It is only by 2031 there will be a decline in the adolescent population of Bangladesh – highlighting the importance of ensuring this national adolescent health strategy is comprehensive and meets the needs of all adolescents, especially the most vulnerable and disadvantaged adolescents. The sheer number of persons in this population cohort, whose health needs have to be addressed, also makes it imperative for this strategy to be effectively implemented.

This significant adolescent population presents a demographic window of opportunity, which, if well harnessed and invested in, will contribute to the development of the country. Investment in adolescent health will have an immediate and direct impact on Bangladesh's health goals and on the achievement of the Sustainable Development Goals (SDGs), especially goals 3 (ensure healthy lives and promote well-being for all at all ages), 4 (ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (achieve gender equality and empower all women and girls), and 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all). Investments in adolescent health will also require supporting programmes and services, which recognize the special needs of adolescents and ensure their needs are addressed both comprehensively and sensitively.

1.3. The Social Context of Adolescent Health

Many adolescents, especially adolescent girls in Bangladesh, are not provided with optimal conditions to develop their full potential and ensure their overall health in their transition into adulthood. The challenges adolescents face, during this transitory phase, are due to a variety of factors including structural poverty, lack of access to information and services, negative social norms, inadequate education, social discrimination, child marriage and early child-bearing for adolescent girls. Adolescents who are marginalized and especially vulnerable because of their living conditions have a set of other, more varied, challenges which further exacerbate this transitional process. Adolescents who live on the streets, in slum dwellings, in char and haor areas, adolescents with disability, married and/or pregnant adolescent girls, adolescents who engage in sex work, adolescent children of sex workers, adolescents in child labour, adolescents who are in detention and adolescents who are refugees/live in refugee camps will need special interventions to meet their overall health needs.

Adolescents continue to experience major constraints in making informed life choices: a significant number of adolescents experience risky or unwanted sexual activity, do not receive prompt or appropriate care and, as a result, experience adverse health outcomes. Adolescent girls also face gender-based discrimination, evident in the practice of child marriage, the high rates of adolescent fertility, the high prevalence of domestic violence, the increasing incidence of sexual abuse and higher drop-out rates from secondary education due to the patriarchal social norms of Bangladesh. Adolescent boys also face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviors such as unsafe sex, violence and substance use. All these factors have a direct as well as indirect influence on the health and well-being of adolescents, and form an essential component of the context within which health issues of adolescents should be understood.

COMMITMENT AND RESPONSE TO ADOLESCENT HEALTH

2.1 Bangladesh's International Commitments to Adolescent Health

As a signatory to the Child Rights Convention and a proponent of the International Conference on Population and Development (ICPD), the Beijing Platform for Action and, more recently, the SDGs Bangladesh has made important commitments to address the issue of adolescent health in the country. These commitments have, in the recent past, translated into results and the country has seen significant improvements in select health indicators including the maternal mortality rate, neonatal and infant mortality rates and adolescent malnutrition rates. Given the significant number of adolescents in the country and their potential role as change agents, any improvement in their health status could trigger an accelerated achievement of the other goals and targets outlined in the SDGs as well as the ICPD Programme of Action and thereby contribute to Bangladesh meeting its commitments to the international community.

2.2 Legal and Policy Responses

The Bangladesh Constitution

The Constitution of Bangladesh guarantees the right to healthcare and medical treatment for all its citizens, irrespective of age, sex, caste, creed and colour. Making comprehensive and quality healthcare services available is the responsibility of the State and the Government of Bangladesh has, through various laws and policies, highlighted the importance they attach to addressing the health of adolescents.

Laws/Acts of Bangladesh to Ensure Adolescent Health

A number of laws are in places, which directly or indirectly contribute to addressing the overall health and wellbeing of adolescents. These include the Children Act 2013, which includes provisions relating to the protection and treatment of children and trial and punishment of child offenders, the Women and Children Repression Prevention Act 2000 (amended in 2003) and the Human Trafficking Prevention and Deterrence Act 2012 enacted to regulate offences including sexual harassment, rape, trafficking, kidnapping, dowry against women and the Child Marriage Restraint Act 1929 (amended in 1983) enacted to restrain child marriage and ascertain the legal age of marriage, among others.

Policies of Bangladesh Supporting Adolescent Health

The Government of Bangladesh has recognized the importance of ensuring adolescent health and has incorporated this issue in several of its policies. These include the Bangladesh Population Policy of 2012, which has the objective of raising awareness among adolescents on family planning, reproductive health, reproductive tract infections and HIV/AIDS. The National Health Policy of 2011 similarly has objectives and strategies which are comprehensive and include addressing adolescent

health through its focus on ensuring good quality health care for all citizens of Bangladesh irrespective of their age, sex, caste, creed, colour and/or place of residence. The Bangladesh National Children Policy of 2013 places significant attention on adolescent development including the development of the girl child. The policy focuses on making quality services, including health services, available to all children and adolescents of Bangladesh. In addition to these policies, the Education Policy of 2010, the Child Labour Elimination Policy of 2010 and the Nutrition Policy of 2015 all contribute to addressing adolescent health issues.

2.3 The Health System Response to Adolescent Health

Interventions of the Government Sector

The Ministry of Health and Family Welfare (MoHFW) has the primary responsibility for addressing the health needs of adolescents and providing quality services for same. The Directorate General of Health Services and Directorate General of Family Planning both have an Operational Plan for addressing adolescent health. Adolescent health related programmes under the purview of the MoHFW include the provision of Adolescent Friendly Health Services (AFHS), school health programmes, counseling and raising awareness among adolescents on reproductive health issues and preventing STIs and HIV/AIDS through education and treatment services. The nutritional supplement programmes for pregnant adolescent mothers, introducing skilled birth attendants and the expansion of Emergency Obstetric Care (EmOC) services including 24/7 delivery centres, immunization programmes for adolescent girls and establishing referral linkages between school health clinics and other health facilities are other initiatives which will directly contribute to improving the overall health of adolescents.

A number of other ministries are also directly responsible for addressing adolescent health issues. The Ministry of Local Government, Rural Development and Cooperatives, under the Urban Primary Health Care Project (UPHCP) provide adolescent health services in a majority of municipalities and all City Corporation areas. The Ministry of Education has included adolescent health issues in the formal school curricula and the Ministry of Social Welfare, through its centers for street children and juvenile delinquents, is providing valuable support, including the health related services, to extremely marginalized groups of adolescents. Legal support and skills training provided to women, including adolescent girls, by the Ministry of Women and Children's Affairs, and the youth advocacy, along with provision of livelihood training and peer education through Youth Clubs, of the Ministry of Youth and Sports, are other important initiatives which deserve special mention.

Role of Development Partners

Development Partners, including UN agencies and bilateral and multilateral donors, have a long history of working in the area of adolescent health. Among UN agencies, UNFPA, WHO, UNICEF and UNAIDS in particular have play a key role in working together with the MoHFW to address adolescent health issues. The focus of these agencies differs, but together they encompass all facets of adolescent health, including education, nutrition, rights, empowerment as well as systemic issues such as monitoring progress and promoting adolescent participation. The role of bilateral donors has primarily been to provide technical as well as financial support through their partners. Along with UN agencies, these bilateral agencies have played a valuable role in highlighting the importance of adolescent health issues and ensuring the availability of services to meet the health needs of adolescents.

Civil Society and the Private Sector Support to Adolescent Health

Non-governmental Organizations (NGOs) played a pioneering role in providing adolescent friendly health services in Bangladesh. A majority of NGOs primarily focused on the provision of health

education, raising awareness on health issues, the delivery of health services for adolescents and the provision of peer education and life skills for capacitating adolescents to claim their rights. A large number of NGOs – both local, national and international have been involved in designing and implementing interventions related to adolescent health. Many of these interventions have used innovative approaches and have been truly responsive to the needs of adolescents. Several NGO supported programmes have been particularly successful in addressing the health needs of highly marginalized groups such as adolescents living on the street, adolescents employed in risky jobs and adolescents working in hazardous environments.

It is important to note that despite extensive engagement of NGOs, their impact in addressing adolescent health issues has been limited. While the reasons for this are manifold, a key factor has been that these interventions are not at a large enough scale to generate a critical national response. Moreover the lack of coordination and collaboration between civil society organizations has also contributed to difficulties in ensuring the availability of a holistic response to meet the health needs of all adolescents.

2.4 Justification for an Adolescent Health Strategy

The first Adolescent Reproductive Health Strategy (ARHS) for Bangladesh was developed in 2006 with the following goal: *“By 2016, all adolescents will have easy access to information, education and services required to achieve a fulfilling reproductive life in a socially secure and enabling environment”*. This strategy was valid for a period of 10 years until the end of 2016. Given the effectiveness of this policy and associated action plan in ensuring that adolescent sexual and reproductive health needs were addressed through the health sector, it was decided to develop a strategy, with a broader focus on overall adolescent health, to be implemented beyond 2016.

The focus on adolescent reproductive health in the previous strategy, while appropriate for the said time period, would not have effectively captured the varied health needs of adolescents in the present context. Therefore in order to better respond to the overall health needs of adolescents, the MoHFW decided to develop a comprehensive adolescent health strategy, which would include sexual and reproductive health as a key component. The broader focus would thus be a paradigm shift in approaching adolescent health because it adopts a combination of strategies to support health promotion, prevent ill health and provide curative care and services to meet adolescent health and development needs.

The current strategy focuses not only on adolescents but also on their social environment, including families, peers and communities. Importantly, the strategy proposes a convergent model of health promotion and service delivery, which will actively engage adolescents through primary health care providers and platforms within community spaces such as schools and adolescent clubs to secure and strengthen mechanisms for access. The strategy also moves away from a 'one-size-fits-all' approach to addressing the specific needs of adolescents in different contexts and aims at instituting effective, appropriate and accessible service packages to address the range of adolescent health and development needs. To implement this paradigm shift, four strategic thematic areas were identified as priority for Bangladesh. These include adolescent sexual and reproductive health; violence against adolescents; adolescent nutrition; and mental health of adolescents. Social and behaviour change and health systems strengthening were identified as cross cutting issues, which will contribute to the effective implementation of the above-mentioned thematic areas.

2.5 The Strategy Development Process

The process of developing the National Adolescent Health Strategy (NAHS) commenced in late 2015 under the leadership of the Maternal and Child Health (MCH) Services Unit of the Directorate

General of Family Planning (DGFP), MoHFW. At the request of DGFP; UNFPA, UNICEF and WHO agreed to support the strategy development process together with input from other Development Partners, Government Agencies and Civil Society Organizations (CSO) who have been working in the field of adolescent health.

A core committee, consisting of members of the MoHFW, the three UN agencies and key CSOs, was formed under the guidance of the Director General (DG) of the DGFP. In addition, relevant technical committees were formed to provide expert input in identifying key thematic areas and related strategic directions. The technical committees worked on the thematic areas and forwarded their input to the core committee for vetting and finalization of each focus area.

Several divisional level consultations and workshops were held to validate the draft thematic areas and identify key priority issues under each theme. The thematic areas were revised subsequent to the consultations and presented to the core committee for their review and approval. The priority issues under each thematic area were reviewed and refined by the technical committees and all sections amalgamated to develop the overall strategy document. The overall draft strategy document was presented to the inter-ministerial committee for their approval and revised subsequent to their comments.

This final version of the strategy is an outcome of several divisional level consultations, workshops, technical meetings and input from policy makers, programme planners, researchers, academicians, adolescents, and community and opinion leaders. Most significantly, the strategy development process included the participation of adolescents during the consultation phase and their input will also be sought in the development of the associated action plan.

CHAPTER 3

FRAMEWORK

3.1 The Vision

By 2030, all adolescent boys and girls of Bangladesh, especially those who are most vulnerable, will be able to enjoy a healthy life.

3.2 The Goal

By 2030 all adolescents will lead a healthy and productive life in a socially secure and supportive environment where they have easy access to quality and comprehensive information, education and services.

3.3. The Time Frame

This strategy will span over a period of 14 years (2017 to 2030) in line with the Sustainable Development Goals. The strategy will be revisited periodically to review and assess its relevance in a rapidly changing context.

3.4 Guiding Principles

The National Adolescent Health Strategy 2017-2030 is based on human rights principles, and highlights the right of all adolescents, those between the ages of 10 and 19 years, to attain the highest standard of health. Detailed below are the human rights and other principles that will guide the implementation of this strategy:

Universality and Inalienability

The right to health will be universal and inalienable for all adolescent boys and girls of Bangladesh. They will be entitled to access health related information and services regardless of their gender, age, class, caste, ethnicity, religion, disability, civil status, sexual orientation, geographic divide or HIV status.

Indivisibility

The right of adolescents to their health has equal status over other rights and will not be positioned in a hierarchical order. The right to adolescent health will not be compromised at the expense of other rights.

Interdependence and Interrelatedness

The right to adolescent health is interdependent and interrelated with other rights and as such will depend, either wholly or in part, on the adolescent's ability to realize their other rights to meet their physical, mental and social needs. For example, the realization of an adolescent's right to health may depend on the realization of her/his right to education or information.

Equality and Non-discrimination

All adolescents, despite their heterogeneity, are equal as human beings and no one should suffer discrimination on the basis of gender, age, class, civil status, ethnicity, geographic divide, (urban/rural), religion, region, disability, sexual orientation and/or HIV status. All adolescent health programmes should therefore respect the diverse needs of adolescents and ensure there is no discrimination in access to essential quality health services.

Participation and Inclusion

All adolescents will have the right to participate in and access information and services, which will contribute to their health. Health services and programmes will therefore be participatory, with increasing scope for active engagement of and expression by adolescents in relation to decision-making. Health services and programmes will also take into account adolescents' felt needs, issues and rights; help them to develop their self-esteem and take responsibility for their wellbeing and relationships.

Capacity Development and Leadership

In addition to the above mentioned human rights principles, this strategy will also be guided by the principle of developing the capacity and leadership skills of service providers. This will ensure that the next generation of health service providers can engage themselves in the development of innovative and effective interdisciplinary approaches to promote adolescent health and provide services with the primary goal of reducing health inequities.

SD1 Adolescent Sexual and Reproductive Health

Problem Statement

Adolescents of Bangladesh, both those who are unmarried and married, have low levels of knowledge and limited access to information and services on sexual and reproductive health and rights (SRHR).

Context

The sexual and reproductive health (SRH) status of adolescents in Bangladesh, both those who are unmarried and married, remains an area of concern for the country. Low levels of knowledge on SRH and STI/HIV, high prevalence of child marriage, correspondingly high levels of adolescent fertility and limited access to quality and age appropriate information and services are challenges, which need to be addressed through adolescent health programming. It is envisioned that interventions which provide quality, age appropriate information and services to adolescents, on their SRH and rights, beginning with the very young adolescent (10-14 years) and continuing until they become adults (18 years onwards) will contribute to improving the SRH status of adolescents in the country.

Bangladesh does not have any nationally representative data, which assesses knowledge levels on SRH and rights among the adolescent population. While this poses a challenge, there are other sources of data, notably those that measure comprehensive knowledge on HIV, which points to the low levels of knowledge among adolescents. According to UNAIDS Bangladesh, only 12.8 percent of adolescents and youth have comprehensive knowledge on HIV (UNAIDS 2016). The BDHS (2014), which highlights that only 12 percent of ever-married adolescents had comprehensive knowledge about HIV/AIDS, is further testimony to the low levels of knowledge on SRH issues among adolescents.

A low level of knowledge, often as a result of the unavailability of accurate information, is often linked to poor SRH outcomes. Globally, it has been established that the provision of quality, age appropriate comprehensive sexuality education has a positive impact on SRH, reducing STIs/HIV and unintended pregnancy (UNESCO 2015). Studies have also shown that comprehensive sexuality education contributes to building communication, negotiation and relationship skills, and positive gender attitudes – which not only impact on SRH but also on mental health. In the current context, while a range of SRH related education programs are being implemented by both government and non-government agencies in parts of Bangladesh, there is a lack of consensus

with regard to course content. Importantly, much of the content does not cover the six priority areas of sexuality education proposed by UNESCO. Furthermore, anecdotal evidence and consultations conducted for the development of this strategy revealed that the delivery of the content remains weak, with teachers often skipping the chapters, or asking students to study them at home.

A significant concern for Bangladesh is the prevalence of child marriage and the corresponding high levels of adolescent fertility. With the highest adolescent fertility rate in South Asia, at 113 live births per 1000 women aged 15-19 years, there is a critical need for Bangladesh to ensure the availability of interventions to reduce adolescent fertility levels (BDHS 2014). These interventions need to start before marriage, so that young girls have adequate knowledge on SRH and can better plan their pregnancies. According to the BDHS (2014) the Contraceptive Prevalence Rate (CPR) among married adolescents is 51 percent and the unmet need for family planning is 17 percent – the former lower than the national average by 11 percentage points and the latter higher than the national average by 5 percentage points.

Encouragingly, it is important to note that the use of antenatal care services from a medically trained provider and facility based delivery are at 64 percent and 36 percent respectively, both which are on par with the national averages for these two indicators. While these indicators show gradual increase over the years, there is room for improvement, especially in light of the fact that adolescent pregnancies lead to higher maternal morbidities – where adolescent mothers are more likely to experience complications during pregnancy and are less likely to be prepared to deal with them (BMMS 2010). Additionally, the under-five mortality rate of children born to mothers below 20 years is 66 deaths per 1000 live births, much higher than 49 deaths per 1000 live births for those with mothers between the ages of 20-29 years (BMMS 2010). Children born to adolescent mothers are also more likely to be underweight – thus contributing to the perpetuation of nutrition related morbidities. Aside from the obligation to prevent child marriage, there is also a need to ensure the SRH status of married adolescents – so that their CPR is increased, the unmet need for FP reduced, facility based delivery and antenatal care services by a medically trained provider increased and the infant/under-five mortality rates of children born to them is reduced.

There is a lack of data on the prevalence of RTI, STI and HIV among adolescents in Bangladesh but they – especially adolescent girls – continue to be vulnerable, both socially and economically, to HIV and STI infections. According to WHO (2013), globally about one-seventh of all new HIV infections occur during adolescence, which makes it imperative for Bangladesh to continue with its interventions which specifically target the very young adolescents, so that they are equipped with the necessary information and knowledge and made less vulnerable. The national policy and strategy aimed at preventing and responding to HIV/AIDS and STIs as well as the National AIDS/STD Program (NASP), are well placed to meet the emerging needs of adolescents in relation to HIV/AIDS/STIs prevention. At the same time, given the lack of data on the prevalence of HIV/AIDS/STIs among the adolescent population and the low levels of knowledge among adolescents, the focus on HIV prevention should continue to be for both community based and most at risk adolescents (MARA).

Finally it is important to address the issue of unmarried adolescents, who fall outside the existing reproductive health care services system, given the regulation that SRH services are available only to married women and eligible couples (Ainul et al., 2016). Meeting the SRH needs of unmarried adolescents, not only by providing them with information, as is the current practice, but also by

making relevant services available and accessible to them becomes imperative if the Government of Bangladesh is to meet the SRH and rights of all adolescents. While there is limited documented evidence, it is known that services to meet the SRH needs of adolescents, including those who are married, are piecemeal and ad hoc. The recent systematic analysis of the effectiveness and gaps of existing adolescent SRH interventions and programs, conducted by Population Council, revealed that health services are not tailored to meet the SRHR and needs of unmarried adolescents (Ainul et al., 2016), highlighting the need to do so and ensuring the special needs of the most vulnerable adolescents are taken into account.

Given this background, and the significant population of adolescents in Bangladesh, where a majority of adolescent girls are given in marriage before the age of 18 years, meeting the sexual and reproductive health needs and rights of this group becomes imperative. These needs can be met by ensuring the provision of quality and age appropriate sexuality education starting with the very young adolescent, the delivery of quality age and gender appropriate SRH information and services and mobilization of the community to accept the importance of meeting the SRH and rights of all adolescents, irrespective of their marital status. The delivery of comprehensive sexuality education and SRH information and services should be in accordance with international standards, adapted to suit the current context of Bangladesh. Investing in the SRH needs of adolescents in Bangladesh will not only contribute to improving the overall health and wellbeing of this population cohort but also to reaping the demographic dividend. An adolescent population which has the necessary knowledge on SRHR and can make informed decisions with regard to their SRH, especially about the desired number of children, the use of modern family planning methods and birth spacing, will also lead to reductions in the country's adolescent fertility rate, which is a significant concern to the country.

Strategic Objectives

1. To create an enabling environment at all levels – national and local – by strengthening legislation, policy development and implementation;
2. To integrate and strengthen age appropriate comprehensive sexuality education programmes at all academic and training institutions;
3. To improve the sexual and reproductive health status of adolescents by engaging a range of evidence based and effective interventions.

Key Strategies

1. Enable evidence based advocacy for comprehensive policy and programme development, investments and implementation;
2. Promote age appropriate comprehensive sexuality education, which are on par with international standards, through all academic and training institutions;
3. Build capacity for the delivery of age and gender sensitive sexual and reproductive health services which includes HIV/STI prevention, treatment and care;
4. Create a robust system for data collection/analysis on the sexual and reproductive health of adolescents, including unmarried adolescents, to inform policy and programming.

SD2 Violence against Adolescents

Problem Statement

Patriarchal gender norms as well as the hierarchical social system in Bangladesh contribute to the practice and justification of violence against adolescents, especially adolescent girls, which leads to various discriminatory and harmful practices including child marriage and domestic violence.

Context

As a patriarchal and strongly hierarchical society, the prevalence of violence is a common and socially accepted phenomenon in Bangladesh. Violence affects children, adolescents and adults alike with girls and women disproportionately experiencing violence – be it from persons known to them, the wider community or complete strangers. A clear manifestation of violence against adolescents, especially adolescent girls, is the high prevalence of child marriage in Bangladesh – according to the most recent BDHS (2014) 59 percent of women aged 20-24 years were married before the age of 18. While there is no nationally representative or documented data on violence experienced by adolescent boys, anecdotal evidence and small-scale studies point to violence experienced by adolescent boys as well.

It is important to note that Bangladesh has seen a decreasing trend in the prevalence of violence against girls and women in the recent past but nevertheless violence and its consequences remain a concern for the country. The Violence against Women Survey (BBS 2015b), highlighted that 42.8 percent and 28.4 percent ever married adolescents aged 15-19 years reported physical or sexual violence during their lifetime and in the last 12 months respectively. Importantly, with regard to non-partner violence, in this same survey 27.8 percent of all interviewed girls and women, regardless of their marital status, have experienced violence in their lifetime. Worryingly, the rates for non-partner violence were highest among adolescent girls (15-19 years) where 30.9 percent had experienced physical violence in their lifetime and 11.2 percent experienced physical violence in the last 12 months. Rates of non-partner sexual violence was second highest among the adolescent age group (15-19 years) for both during their lifetime - 3.4 percent and in the last 12 months - 3.1 percent (BBS 2015b). What this data suggests is that adolescent girls, regardless of their marital status, continue to be vulnerable to all forms of violence which then makes it imperative to put in place preventive mechanisms, from both a socio-economic and a health perspective.

As mentioned at the outset, child marriage, defined as any marriage before the age of 18 years, is a clear indicator of discriminatory gender norms and violence against adolescents. Bangladesh has the highest rate of child marriage and adolescent fertility in South Asia. Child marriage in Bangladesh is overwhelmingly among adolescent girls and the median age at first marriage for women aged 20-24 years is 17.2 years (BDHS 2014). Closely linked to child marriage, is the high adolescent fertility rate of 113 live births per 1000 women aged 15-19 years. According to the BDHS (2014), 31 percent of adolescents aged 15-19 years have begun childbearing, about 1 in 4 has given birth, and another 6 percent were pregnant with their first child. While there is no established data on the prevalence of child marriage among adolescent boys, such marriages have been anecdotally documented in rural areas and among certain communities albeit in much lower numbers.

A significant problem in Bangladesh is the lack of nationally representative or scientifically reliable data on the prevalence of violence against adolescent boys. A study conducted in four districts of Bangladesh revealed that 9.8 percent of school going adolescent boys reported experiencing sexual violence and for a majority of them the perpetrators were other boys from school (HDRC 2015). In

this same study only 4.2 percent school going adolescent girls reported experiencing sexual violence but it is important to read this data with caution because one possible explanation for this lower percentage is that adolescent girls did not report sexual harassment as violence given the pervasiveness, the acceptance of this practice and the fear of social stigma. Still for all a key message from this finding is that adolescent boys also experience violence and, while there is a dearth in nationally representative data, there is a need for the implementation of interventions to prevent violence against adolescents.

According to BDHS (2011), women aged 20-24 years who were married before 18 were more accepting of domestic violence than women married after 18 years – highlighting the intricate links between a culture of violence, child marriage, adolescent fertility and the potential health consequences. It is also important to note that adolescent boys often also face the pressure to conform to the prevailing hegemonic masculinity ideal, which can then drive them to perpetrate violence and engage in risky behaviors such as unsafe sex and substance use.

Violence against adolescents, both boys and girls, is serious social issue for Bangladesh and its aspirations to meet the SDGs by 2030: if one fifth of the population is at risk of experiencing GBV, it will affect the country's possibility of reaping the demographic dividend. Moreover, it is also an economic and a health issue because experiences of violence and exposure to violence often lead to both mental and physical consequences such as low self-esteem, depression and physical injury. The economic cost associated with violence against adolescents goes beyond the immediate costs which the health sector has to bear because adolescents who experience and witness prolonged violence may also not be as well equipped to contribute to the economy of the country. In this context, it becomes crucial for the health sector to prevent the practice and the acceptance of violence through innovative educational and awareness raising interventions which highlight the consequences of violence, so that adolescents can enjoy a life free of violence. The health sector response to GBV needs to identify the specific health needs of adolescent boys and girls and ensure the availability of information and services to meet these needs effectively.

Strategic Objectives

1. To promote positive social norms which address age and gender based discrimination and violence, including child marriage by engaging and influencing policy makers and key stakeholders;
2. To empower adolescents, especially adolescent girls, by providing them with life skills to stand up for their rights, including their rights to fully and freely consent to marriage;
3. To strengthen health and social protection systems to provide services to meet the needs of the most vulnerable adolescents.

Key Strategies

1. Enable evidence based advocacy and communication at national and local level to raise awareness on the issue of age and gender based discrimination, child marriage and its consequences;
2. Build the capacity of the health and social protection sector to respond to age and gender based violence and child marriage prevention by providing effective and efficient services;
3. Develop and implement evidence based programmes to prevent and mitigate the consequences of age and gender based violence, including child marriage;
4. Create a robust system for data collection/analysis on the prevalence of age and gender based violence to be used to inform policy and programming.

SD3 Adolescent Nutrition

Problem Statement

Malnutrition, micronutrient deficiencies and other nutrition related diseases among adolescents, particularly adolescent girls contributes to the perpetuation of intergenerational malnutrition.

Context

Adolescence is a period of rapid physical, mental and emotional growth, characterized by the development of the brain and related cognitive capacities which are the foundation of overall health and well being. The nutritional requirements during adolescence is significant and a key requisite to attain optimum growth in this important stage of life. A well-nourished adolescent girl will have a multi-generational impact because a healthy, mature and well-nourished woman, is more likely to deliver babies with appropriate birth weight. A strong start in life is essential to break the intergenerational cycle of under nutrition and a well-nourished adolescent is also more likely to lead a healthy life during adulthood, with fewer risks of non-communicable diseases in later life. The global review on adolescent nutrition (WHO, 2005) suggested that the main nutritional issues of adolescents in low- and middle-income countries are under nutrition and associated deficiencies which often originate during childhood.

According to the Bangladesh Demographic Health Survey, 2014, the prevalence of thinness/underweight (Body Mass Index less than 18.5) among married-adolescents of 15-19 years old is very high at 31 percent. Moreover with 13 percent prevalence of short stature (less than 145cm), women are at greater risk of mortality and complications during delivery and also increased likelihood of delivering babies with low birth weight. Research also shows that adolescent pregnancy and lactation leads to poor linear growth and fat depletion in new born children (Rah et al., 2008). Other assessments and studies which focus on adolescents and women of reproductive age show that stunting and anaemia are also major health concerns. Nationally, 29 percent of adolescent girls are short for their age with notable differences between urban and rural areas at 21 percent and 30 percent respectively (FSNSP, 2013).

The most immediate cause of under nutrition in Bangladesh remains inadequate dietary intake of nutrient rich foods. While current nationally representative data among adolescents in Bangladesh is still scarce, a study conducted in 1998 showed that among urban school girls in Bangladesh, only 9 percent and 17 percent met the Recommended Dietary Allowance (RDA) for energy and protein, respectively (Ahmed et al., 1998). Gender based discrimination is widely recognized as a primary underlying cause of under nutrition in Bangladesh (Sen and Hook, 2012). Recent data (FSNSP, 2013) shows that, in times of food scarcity, women are the first to deliberately sacrifice their own food intake in order for other household members to have enough food. It is important to note that adolescent under nutrition is inextricably linked to persisting gendered discrimination and social norms, particularly child marriage, adolescent pregnancy and the level of a girl's education. According to the BDHS (2011), levels of child under nutrition fall with increasing education level of mothers, as well as maternal height thus highlighting the importance of education. And it has been found that irrespective of socio-economic class, there is a positive correlation between education/literacy and nutrition and dietary diversity (IFPRI, 2013).

Finally, another emerging spectrum of malnutrition, is the rising levels of overweight and obesity among adolescents. According to BDHS (2014) the prevalence of overweight and obesity among married adolescents increased from 3 percent in 2007 to 7 percent in 2014. This means that Bangladesh has to start addressing the double burden of under nutrition/malnutrition and overweight/obesity among adolescents – among both those who are married and unmarried.

Strategic Objectives

1. To reduce under nutrition and anaemia among adolescent girls (pregnant and non-pregnant) and boys;
2. To reduce the risk of low birth weight babies, pregnancy related complications and nutritional risks among adolescent girls;
3. To reduce micronutrient deficiencies such as Calcium, Vitamin D and Iodine deficiency among pregnant adolescent girls;
4. To improve lifestyles and reduce the risks of overweight and obesity among all adolescents.

Key Strategies

1. Mainstream nutrition education and promotion and hygiene education including hand washing into the health care system, education system as well as other systems which reach out-of-school adolescents;
2. Establish programmes that promote dietary diversification, dietary adequacy, fortified foods and nutrition security through community and school based interventions;
3. Strengthen the capacity of service providers to deliver effective nutrition counselling and services to all adolescents, with a special focus on raising awareness on the consequences of child marriage and meeting the nutritional needs of pregnant adolescent girls;
4. Provide and promote micronutrient supplementation (i.e. IFA and MMS), consumption of fortified foods and de-worming at health facilities, schools, and workplace;
5. Conduct community based awareness campaigns on the importance of good nutrition, healthy foods and the consequences of malnutrition, anaemia and obesity on the overall development and growth of adolescents;
6. Promote and improve access to sports and physical activity in the community, schools and at the workplace.

SD4 Mental Health of Adolescents

Problem Statement

Mental ill health is an important but under-recognized and neglected public health problem. It especially affects adolescents in Bangladesh who do not have access to effective public mental health services due to scarcity of skilled workforce, inadequate financial resource allocation and social stigma.

Context

Like many other countries across the world, awareness about mental health, mental illness and acceptance of treatment for it are very low in Bangladesh, primarily due to social stigma and superstition. The report of the National Mental Health System in Bangladesh (WHO 2007), showed that 16.1 percent of the adult population (aged 18 years or older) of Bangladesh suffer from some form of mental disorder. A systematic review on the mental health situation of Bangladesh revealed that the overall prevalence of mental ill health varied from 6.5 to 31 percent among adults and from 13.4 to 22.9 percent among children (Hossain et al., 2014). Importantly, similar to data on the SRH status of adolescents, there is limited data on the mental health situation of adolescents. Much of the available mental health related statistics focuses on adults and children of the country and therefore it is difficult to critically assess the mental health status of adolescents in the country. The wide range in the reported prevalence estimates strongly suggests that mental disorders constitute a significant public health problem in Bangladesh.

As mentioned above, the dearth of information on the prevalence of mental health problems among adolescents, poses a challenge for developing interventions to support the mental health of adolescents. While comprehensive mental health assessments of adolescents are rare in Bangladesh, in their study into the prevalence of depression, Nasreen et al., (2013) concluded that depressive symptoms were common among adolescents in Bangladesh, with a predominance among adolescents living in urban slums and adolescent girls. They also found that reproductive health problems and sexual abuse were associated with depressive symptoms for girls. However, more than 80 percent of depressed adolescents sought no help, indicating the need for accessible adolescent friendly services such as community-based counselling. A needs assessment survey among urban adolescents done by BRAC and Population Council (Amin 2015) showed that individual factors associated with depression included marriage, childbearing, experiences of harassment, drug use, poor performance in school and experience of disasters/conflict during childhood. This same study showed that adolescent girls who have never been pregnant had less symptoms of depression than those who had been pregnant and were mothers. Moreover, women who had experienced adolescent pregnancies are more likely to report signs of moderate to severe depression.

In addition to mental health concerns, drug related problems are gradually becoming a key concern in Bangladesh from a social, economic and, more importantly, health perspective. According to the Department of Narcotic Control of Bangladesh (1995), 1.5 million Bangladeshi's were involved in abusing drugs of various kinds. However, there is a serious lack of research and data on how drug use affects adolescents and the impact it will have on their overall wellbeing and future health.

In order to get a comprehensive understanding of the mental health needs of adolescents, it is important to situate adolescence within the dynamic sociological, cultural and economic realities of their life. In this regard paying special attention to the needs of very young adolescents, who are not in a position to make 'informed choices' is very important. This period, between 10 and 14 years also represents a key opportunity for health promotion and the prevention of unhealthy behaviour that increases the risk of mental health diseases and other potential non-communicable diseases. Finally, addressing issues such as early childhood development, parenting, domestic violence, sexual abuse especially by family members etc. are also of importance when looking into meeting the mental health needs of adolescents.

Strategic Objectives

1. To integrate the mental health agenda within primary health care services and other relevant health and education services;
2. To promote mental health and prevent mental ill health by implementing a range of evidence based interventions and screening for common mental illnesses and suicidal behaviour as per the provisions of primary mental health care;
3. To create an enabling environment for mental health services including counselling and to develop the capacity to provide effective services at all levels of facilities.

Key Strategies

1. Enable evidence based advocacy for comprehensive programme development to promote mental health among adolescents and reduce stigma against mental ill health;
2. Develop skills among adolescents to deal with stress, manage conflict and develop healthy relationships;
3. Develop the capacity of the health sector to address mental health issues as per the provisions of primary mental healthcare and to screen for anxiety, stress, depression and suicidal tendencies;
4. Promote school and facility level interventions which include counselling and management of mental health disorders through linkage with the national mental health programme;
5. Create a robust system for data collection/analysis on mental health issues including substance use, to inform policy and programming.

Cross Cutting Issues

CCI 1 Social and Behavior Change Communication

Problem Statement

Adolescents face challenges in voicing their concerns and are often given limited decision making power. Social and Behavioural Change Communication (SBCC) programmes which can empower adolescents to participate in decision making processes and ensure they seek appropriate health information and services need to be scaled up and strengthened. In order to ensure adolescents are able to participate in decision making processes, SBCC programmes moreover need to focus strongly on changing the attitudes and behaviours of gatekeepers, including parents, family members, teachers and service providers to respect adolescents' opinions, needs and interests.

Context

Meeting the overall health needs of adolescents, given the stigma, myths and taboos associated with adolescent health issues, is a challenge in Bangladesh. Adolescents have some access to information relating to their health, but this information is not provided through means that have the power to change existing negative behaviours, maintain positive behaviours and adopt more responsible and effective behaviours, which will contribute to health promotion. As a result, there is a need to collaboratively adopt an effective SBCC campaign if we are to ensure the health of all adolescent boys and girls of Bangladesh.

A recent research conducted in Bangladesh, by the International Centre for Research on Women (ICRW), found adolescents lack access to health facilities, particularly to meet their sexual and reproductive health needs (ICRW 2014). This study further affirmed what is often commonly known: the underlying reasons cited by adolescent girls for not accessing SRH services include embarrassment, superstition, lack of knowledge and the obstacles posed by older family members. These obstacles, including shame and stigma associated with being sexually active and the threat of violence, are often due to gendered norms, which as mentioned in the above sections, also lead to issues of child marriage, inadequate nutrition, adolescent pregnancy, and school dropouts. In another study, ICDDR,B found that adolescents face many health problems and often do not have access to adequate information to address these problems or even know who to approach. Equally importantly, this study also revealed that most girls don't have any knowledge about menstruation before they experience it given the taboos around menstruation.

This lack of access to accurate and reliable information and the various taboos and myths which are commonplace, necessitates a comprehensive approach to addressing adolescent health and social wellbeing, by ensuring effective SBCC interventions for each of the above mentioned thematic areas. SBCC is the systematic application of interactive, theory based and research driven communication processes and strategies to address “tipping points” for change at the individual, community and social levels (FHI360, 2011). The effective implementation of this NAHS will require SBCC strategies which focus on the 'tipping points' and ensure that adolescents are empowered to voice their opinions and seek the services they require to maintain their overall health.

Strategic Objectives

1. To ensure political commitment and adequate resources to support SBCC interventions;
2. To promote social mobilization and ensure wider participation, coalition and ownership of issues which affect adolescents among community members;
3. To use SBCC interventions to bring about changes in knowledge, attitudes and practices among specific audiences.

Key Strategies

1. Development of messages and materials for communication and advocacy through sound research;
2. Utilize ICT (including call centres) and media to reach adolescents, key community members, parents and guardians;
3. Develop the capacity of respective institutions and systems to design, plan, implement and monitor SBCC interventions.

CCI 2 Health Systems Strengthening

Problem Statement

A comprehensive strategy, to meet the overall health needs of adolescents, where multi-faceted factors need to be taken into consideration will challenge the capacities of the existing health system. Therefore, implementing a new strategy will require further strengthening of the health system to meet the goals detailed in the strategy.

Context

The concept of adolescent health has to be understood from a multi-dimensional perspective and an effective response to meeting the health needs of adolescents require a multi-sectoral and multi-disciplinary approach. As such, the effective implementation of adolescent health programs will depend on a coordinated approach and is the collective responsibility of a range of line ministries, departments and agencies, non-governmental organizations, the private sector, religious authorities, communities, families and individuals. However, as the focal Ministry for adolescent health, the Ministry of Health and Family Welfare has the overall responsibility to ensure its systems are strengthened and can meet the health needs of this large population cohort. This strengthening of the health sector response to adolescent health needs to be conducted through a systematic process, which applies at the national, district and sub-district health facility levels, in line with the Essential Services Package (ESP) of the Government of Bangladesh.

The WHO Health Systems Framework (WHO 2007) refers to six building blocks of a health system that need to be strengthened if we are to ensure the availability of effective services which meet the health needs of adolescents and thereby improve their health status. These building blocks include leadership/governance, healthcare financing, health workforce, health information systems, access to essential medicines and service delivery. The effective implementation of this National Adolescent Health Strategy will require each of these building blocks to be strengthened and for the Ministry of Health and Family Welfare to play a lead role in this process.

Leadership and Governance will entail the Ministry ensuring the effective implementation of this strategy and corresponding action plan, in addition to playing an effective oversight and regulatory role. This leadership role also entails setting standards for quality of care to minimize variability, ensuring equity in access to services, improving the quality of services and meeting the rights of adolescent clients who are seeking health services. The capacity of health managers at all levels in strategic positions should be increased to play this essential oversight and leadership role.

Key Strategies

1. Capacity building of health personnel in strategic leadership positions to develop and manage services for adolescents;
2. Strengthen partnerships with all relevant actors at the highest level – both government and non-government – to deliver effective services which meet adolescent health needs;
3. Provide leadership in mainstreaming adolescent SRH services at all levels of service provision according to the ESP.

Healthcare Financing recognizes the importance of ensuring adequate budget allocation to meet the special needs of adolescents. The Government of Bangladesh has a responsibility to increase financial resources to provide comprehensive, equitable and quality healthcare services for all adolescents – especially those who are most marginalized and vulnerable. Healthcare financing also entails mobilizing resources including through public private partnerships and through support from Development Partners to ensure the availability of quality adolescent health programmes.

Key Strategies

1. Evidence based advocacy to increase budgetary allocation to provide SRH information and services at national, district and sub-district level to adolescents;
2. Establish mechanisms to mobilize financial resources through effective partnerships with Development Partners and the private sector;
3. Improve efficiency and accountability in resource allocation and utilization.

The capacity of the **Health Workforce** will need to be strengthened to meet the health needs of adolescents, which will differ from the needs of the general population. The health workforce should be competent, responsive, efficient and, more importantly, sensitive to the specific needs of different groups of adolescents. In addition to having an effective mix of staff, it is also important to ensure the health workforce receives adequate training to provide adolescent friendly health services through pre-service curriculum revision, on the job training, mentorship and effective supervision.

Key Strategies

1. Capacity building of health providers to be sensitive to the needs of all adolescents, including those who are unmarried, through pre service, in service and on the job training;
2. Provide health service personnel with training on counselling for adolescents and capacitate them to adopt non-judgemental attitudes when working with adolescents;
3. Strengthen quality assurance and monitoring mechanisms to ensure consistent quality in the delivery of services.

A robust **Health Information System** will underpin the effectiveness of all building blocks of health systems strengthening since quality data and information are essential for policy development, health financing, programme design, service delivery, governance and regulation and human resource development. The collection of age and gender disaggregated individual level data, health facility level data, population level data and public health surveillance are underpinned through this strategy since this data will help identify problems and needs, make evidence based decisions and allocate resources optimally – so that adolescent health needs are effectively addressed.

Key Strategies

1. Strengthen the Health Management Information System (HMIS) to collect age and gender disaggregated data on issues which pertain to adolescents;
2. Engage in evidence based advocacy using the data from the HMIS to provide improved and more effective services to meet the health needs of adolescents;

3. Ensure the effective use of the HMIS data to continuously improve the quality of care and service delivery.

The building block of Access to Essential Medicines calls for medicines to be available in the health facilities at all times, in adequate amounts, appropriate dosage, with assured quality and at a price which is affordable to adolescents, especially those who are most vulnerable. Given the focus on adolescent sexual and reproductive health, adolescent nutrition and mental health – essential medicines should, in addition to the list of 14 medicines stipulated by WHO, also include contraceptives, nutritional supplements such as iron folate and other relevant drugs. While ensuring the availability of essential medicines, this strategy calls for a key focus on making these medicines available for free or at low cost – given the target group under consideration.

Key Strategies

1. Ensure the availability of essential medicines, supplements, vaccines and technology at all health facilities at national, district and sub-district level;
2. Facilitate equitable access to all essential medicines and medical technology by putting in place systems to meet the needs of the most vulnerable adolescents;
3. Establish linkages with institutions offering quality assurance of all medicines and commodities needed for adolescents.

Service Delivery is the building block, which is closest to the persons who will benefit from health systems strengthening and is an immediate output of the inputs into the health system. Effective service delivery, which is affordable and of high quality, from the Government, NGOs and the private sector in rural as well as urban areas, will be essential if adolescents are to feel motivated to use health services in their locality. The dimensions of service delivery that need special attention when addressing the health needs of adolescents include quality of care, person centeredness, continuity and accessibility. In addition comprehensiveness, coverage, coordination, accountability and efficiency should also be the focus of the strategy when strengthening the health system to meet the health needs of adolescents in Bangladesh.

Key Strategies

1. Strengthen the service delivery mechanism to ensure the quality of care and comprehensiveness along with other essential dimensions;
2. Establish minimum standards for delivery of services to be adhered to by the Government, NGOs and the private sector.

Vulnerable Adolescents and Adolescents in Challenging Circumstances

As special adolescent population groups, vulnerable adolescents and adolescents in challenging circumstances, have a range of needs which will specifically need to be addressed through the above mentioned Strategic Directions (SDs) and Cross Cutting Issues (CCI). This special group of adolescents include but are not limited to adolescents who live on the streets, in slum dwellings, in char and haor areas, adolescents with disability, married and pregnant adolescent girls, adolescents who engage in sex work, adolescent children of sex workers, working adolescents, adolescents who are in detention, adolescents living in areas prone to natural disasters and adolescents who are refugees/live in camps. Given the population density of Bangladesh and the significant population of adolescents, vulnerable adolescents and adolescents living in challenging circumstances, amount to a significant number. However, data of these special adolescent population groups is often not available or, when it is, not reliable. It is important to note that, given the vulnerabilities of these groups of adolescents, adopting a holistic approach when addressing their needs, is paramount for their wellbeing.

The Constitution of the People's Republic of Bangladesh guarantees social security and public assistance to vulnerable populations – including the sick, unemployed, aged, widowed, orphaned and those with disabilities. The Ministry of Social Welfare has the primary responsibility for ensuring the overall wellbeing – including ensuring equal access to education and health – of these vulnerable groups, including those who are mentioned above. While the Ministry of Social Welfare administers a number of safety net programmes which look into meeting the needs of vulnerable groups, it lacks a focus on the special needs, especially the health and educational needs, of these adolescents. This limitation can be attributed to the lack of data on these groups, a poor understanding of their issues/needs as well as inadequate resources to meet their needs.

Despite the limited data on these vulnerable adolescents and adolescents living in challenging circumstances, it has been established globally that when it comes to the health of these groups it is imperative to allocate resources and conduct tailored programmes. These programmes should not only address their health needs but also take into consideration issues of affordability and accessibility of the health services that are made available. Many of these adolescents come from the socio-economically most disadvantaged segments of society and therefore their health needs will need to be understood through a more holistic and broader perspective. For example, when working with street children, it is essential to explore options of providing them with shelter, schooling, food and psychosocial support – as a basic minimum – if their overall health needs are to be met (Clarke 2016).

The wide acceptance of child labour (which includes adolescents who work), put the physical and mental development of these adolescents at risks (UNICEF 2010). A study conducted by Population Council (Amin, 2015) among urban adolescents revealed that approximately one third of all adolescents are engaged in paid employment with adolescent girls on average working 40 hours per week while adolescent boys work 50 hours per week. Adolescent girls in sex work are even more vulnerable – because aside from this being a fundamental violation of their rights – they are also vulnerable to trafficking, sexually transmitted infections and unwanted pregnancies. Poor mental health and elevated levels of moderate to severe depression are also important areas of concern among urban adolescents (Amin2015), highlighting the need to specifically focus on addressing these needs among urban adolescents.

Low levels of knowledge on sexual and reproductive health and rights due to lack of access to information sources, high levels of child marriage and adolescent fertility are also issues faced by adolescents living in urban areas, including in slum dwellings (Dutta et al., 2015). In relation to adolescents with disabilities, while there is some data on the prevalence of disability among children, the figures vary and are not disaggregated by age. For example in Bangladesh, estimates of children with disabilities range from less than 1.4 percent to as much as 17.5 percent (UNICEF 2014), highlighting the difficulties in estimating the prevalence of disability among adolescents. The higher vulnerability of adolescents with disabilities, when compared with their peers, in accessing education, information on health, sexual and reproductive rights (and rights in general) and their vulnerability to higher incidence of violence including sexual violence makes it important to address disability as a cross cutting issue. Another important consideration for adolescents living with disability, is to cater interventions to meet the specific health needs according to the type of disability. Moreover, as a signatory and ratifying State to the United Nations Convention of the Rights of Persons with Disability (UNCRPD), the Government of Bangladesh, has an obligation to meet the needs of persons with disability.

In light of the above, ensuring the availability of interventions to address the special needs of this vulnerable group will be a priority for the health sector. Within these vulnerable groups of adolescents, it is crucial to identify those who are furthest behind and reach them first. In addition, the interventions for this group of adolescents will need to be multi-sectoral and require a collaborative effort by all actors of the development sector.

Key Strategies

1. Develop a system for data collection/analysis on vulnerable adolescents with a special focus on their health issues and needs, to inform policy and programming;
2. Strengthen the health service delivery mechanism to ensure the provision of specialised services, which meet quality standards and comprehensiveness, to meet the needs of all vulnerable adolescents;
3. Identify specific interventions, under each of Strategic Directions and Cross Cutting Issues mentioned above, which should be implemented for vulnerable adolescents;
4. Establish linkages and develop a network among all development actors, who work with vulnerable adolescents to meet their varied and specialised needs;
5. Support interventions which assist vulnerable adolescents and bring them into the mainstream and provide them with their basic rights such as right to education, health, social welfare and decent employment when they are of age.

IMPLEMENTATION

The implementation of the National Adolescent Health Strategy will require a concerted and coordinated effort among all relevant partners in the field of health. Of primary importance is the engagement of all key Ministries who will have to collaborate with the MoHFW and play a supportive role. In addition to these Ministries and the associated units, Development Partners and Civil Society will also have to play a crucial role in the implementation of activities which will contribute to meeting the goal outlined in this strategy. In order to coordinate these different actors and to ensure the effective implementation of activities, establishing a '*Management and Coordination*' structure becomes imperative. This '*Management and Coordination*' structure will fall under the direct purview of the Directorate General of Family Planning as the principal custodian for the implementation of the National Adolescent Health Strategy. The functions of the '*Management and Coordination*' structure are detailed below.

Management and Coordination

Adolescent health requires a multi-sectoral, multi-disciplinary and multi-dimensional approach if we are to effectively meet the needs of all Bangladeshi adolescent boys and girls. Therefore the effective implementation of this strategy will depend on the collective responsibility of government ministries, departments and agencies, civil society organizations, the private sector, religious authorities, communities, families and adolescents themselves. All these bodies have a strategic and complementary role they need to play in the next 14 years.

5.1 The Role of the MoHFW

The MoHFW holds the primary responsibility for ensuring the health of adolescents. They will have the onus of delivering services, which meet the varying health needs of adolescents and providing health related information. Both the Directorate General of Health Services and Directorate General of Family Planning under MoHFW have an Operational Plan for Adolescent Health and the implementation of this Operational Plan will be crucial to achieve the goal of this national strategy.

5.2 The Role of Other Ministries

The implementation of the NAHS will require the collaboration of a number of other Ministries. All these Ministries will need to both work with the MoHFW and each other – so that a holistic approach to adolescent health becomes a reality for Bangladesh. Other focal Ministries include Local Government, Rural Development and Cooperatives; Education; Social Welfare; and Women and Children Affairs. All these Ministries, through the various programmes implemented by them, will contribute to addressing the health needs of all adolescents. Detailed below are a few key programmes, which will need to be continued in collaboration with the MoHFW:

- The Ministry of Local Government, Rural Development and Cooperatives: the provision of adolescent health services in municipalities and all City Corporation areas;

- The Ministry of Education: inclusion of adolescent health issues in the formal school curricular;
- The Ministry of Social Welfare: establishment of centres to meet the health needs of street children and juvenile delinquents;
- Ministry of Women and Children Affairs: the provision of services and skills training for young women and adolescent girls.

5.3 The Role of Development Partners

All Development Partners, including UN agencies, bilateral and multilateral donors and civil society have a long history of supporting the health sector, with a special focus on adolescent health. These partners will need to continue in their concerted efforts to address the issue of adolescent health by focusing on the different aspects, including education, rights, empowerment, systems strengthening and participation. In addition, academia, research institutions, and media also have a catalytic role to play in promoting adolescent health by generating evidence and disseminating this evidence to the broader community.

The overall responsibility for the implementation of the NAHS at the national and sub-national level rests with the MoHFW. Under the leadership of the MoHFW, both DGFP and DGHS need to take the key responsibility for the related components. The MoHFW will establish relevant Committees with sectoral representation to ensure quality implementation at divisional and district levels. At divisional, district and upazila level similar multi-sectoral coordination mechanisms will need to be established where DGFP and DGHS will ensure the delivery of services at community level to the most vulnerable and marginalized adolescents. The effective management and coordination of the NAHS will ensure that all Bangladeshi adolescents benefit from this strategy and, in line with the SDG principle, 'no one is left behind'.

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ANNEXURE

Member of the Core Committee

(not according to seniority)

	Designation	Organization	
1	Dr. Kazi Mustafa Sarwar Director General	DGFP	Chairperson
2	Sheikh Md. Shamim Iqbal Director (Admin) & Former Acting Director General	DGFP	Former Chairperson
3	Dr. Mohammed Sharif Director (MCH Services) & Line Director (MCRAH)	DGFP	Co-Chairperson
4	Dr. Jahangir Alam Sarker Director (PHC) & Line Director (MNC&AH)	DGHS	Co-Chairperson
5	Dr. Muhiuddin Osmani Joint Chief, Planning Wing	MoHFW	Member
6	Md. Ferdous Alam Director IEM	DGFP	Member
7	Dr. Md. Mainuddin Ahmed Line Director CCSDP	DGFP	Member
8	Pranab Kumar Neogi Director (Finance) & Line Director (FSDP)	DGFP	Member
9	Prof. A H M Enayet Hossain Line Director NCD	DGHS	Member
10	Dr. A B M Muzaharul Islam Line Director, NNS	DGHS	Member
11	Dr. Md. Anisur Rahman Line Director, NASP	DGHS	Member
12	Dr. Syed Abu Jafor Md. Musa Special Advisor	UNFPA	Member
13	Ubaidur Rob Country Director	Population Council	Member
14	Prof. Dr. Rowshan Ara Begum President	OGSB	Member
15	Dr. Golam Shah Jahan Program Manager (A&SH)	DGHS	Member
16	Dr. Riad Mahmud Health Specialist, MNH	UNICEF	Member
17	Eshani Ruwanpura Program Specialist	UNFPA	Member
18	Dr. Muhammad Munir Hussain National Professional Officer	UNFPA	Member

Designation		Organization	
19	Dr. Rabeya Khatoon National Professional Officer	WHO	Member
20	Dr. Ikhtiar Uddin Khondaker Health Advisor	Plan International Bangladesh	Member
21	Dr. Rudaba Khondker Country Manager	GAIN	Member
22	Noor Mohammad Executive Director	PSTC	Member
23	Dr. Shimul Koli Hossain Program Manager (A & RH)	DGFP	Member Secretary

Technical Committees

(not according to seniority)

	Name	Designation	Organization
1.	Dr. Md. Abul Hossain	Project Director MSPVAW	MoWCA
2.	Dr. Md. Anisur Rahman	Deputy Director, NASP	DGHS
3.	Dr. Nurun Nahar Begum	Program Manager CCSDP, UNit	DGFP
4.	Shalina Akther	Deputy Director, MIS Unit	DGFP
5.	Md. Abdus Salam	Deputy Chief, Bureau of Health Education	DGHS
6.	Dr. Md. Shamsul Karim	Program Manager FSDP Unit	DGFP
7.	Zakia Akhter	Deputy Director, IEM Unit	DGFP
8.	Dr. Md. Jaynal Haque	PM (A & RH), MCH Services Unit	DGFP
9.	Dr. Shafiur Rahman	Deputy Program Manager (A & SH)	DGHS
10.	Dr. Nasreen Khan	Technical Support on Nutrition to Additional Secretary (PH & WHO) Country Focal Person for Nutrition and SUN	MoHFW
11.	Prof. Sameena Chowdhury	Professor, Gynae & Obs	OGSB
12.	Md. Mahbubul Alam	Deputy Program Manager FSDP Unit	DGFP
13.	Dr Quamrun Nahar	Sr. Director(Acting), Health System & Population Studies Division	icddr;b
14.	Dr. Lima Rahman	CoP, HIV Program	Save the Children
15.	Dr. Khan Moududur Rahman	Professor, Nutrition	INFS, University of Dhaka
16.	Md. Aman Ullah	Deputy Program Manager NNS	DGHS
17.	Anuradha Narayan	Chief, Nutrition Section	UNICEF
18.	Dr. Suchi Karim	Gender & SRHR Specialist	BRAC University
19.	Md. Moniruzzaman	National Consultant, NCD	WHO
20.	Professor Ferdousi Begum	Professor Gynae & Obstetrics	SSMC&H
21.	Dr. Azizul Alim	Deputy Program Manager, MNH	DGHS

Technical Committees (contd.)

(not according to seniority)

	Name	Designation	Organization
22.	Dr. Naimun Nessa	Assistant Director, MCH Services Unit	DGFP
23.	Dr Abu Sayed Hasan	Technical Officer, FP	UNFPA
24.	Shireen Hussain	Specialist, C4D	UNICEF
25.	Mushfiqa Zaman Satiar	Advisor, SRHR & Gender	Embassy of the kingdom of the Netherland
26.	Dr. Zeba Mahmud	Country Manager	Alive & Thrive
27.	Dr. Md. Mustafizur Rahman	Country Director	Micronutrient Initiative
28.	Dr. S M Shahidullah	Country Director	Ipas
29.	Dr. Iftekhar Rashid	Nutrition Specialist	USAID
30.	Rashida Parveen	Sr. Program Manager Adolescent Development Program	BRAC
31.	Roshni Basu	Gender & Development Specialist	UNICEF
32.	Myang Sari	Nutrition Specialist	UNICEF
33.	Dr. Syeda Nabin Ara Nitu	Technical Specialist-SRHR	Plan International Bangladesh
34.	Shakil Mahmud Chowdhury	Manager –Adolescent Development	Save the Children
35.	Dr. Ireen Akhter Chowdhury	Nutrition Officer	UNICEF
36.	Sigma Ainul	Program Officer	Population Council
37.	Dr. Ana Islam	Project Manager-EC SRHR	Plan International Bangladesh
38.	Israt Jahan Baki	Technical Officer	UNFPA
39.	Dr. Ferdousi Begum	Project Management Specialist	USAID
40.	Dr. Farzana Bilkis	NPO, Nutrition & Food Safety	WHO
41.	Dr. Fariha Haseen	Assistant Professor, Dept. of Public Health & Bio-Informatics	BSMMU
42.	Dr. M Ziya Uddin	HIV/AIDS Specialist	UNICEF
43.	Dr. Shahana Nazneen	Consultant	Innovation for Poverty Action
44.	Fatema Laizu	PDO, Capacity Building	CARE Bangladesh
45.	Dr. Md. Jahangir Hossain	Program Manager	CIPRB
46.	Mahbuba Haque Kumkum		PSTC

Technical Committees (contd.)

(not according to seniority)

	Name	Designation	Organization
47.	Jamila Akhter	Child Protection Specialist	UNICEF
48.	Dr. Selina Amin	Sr. Advisor, Health System, MaMoni-HSS	Save the Children
49.	Dr. Kallol Chowdhury	Joint Director	DSK
50.	Ismat Jahan	Head, Trauma Counseling Center	MSPVAW, MoWCA
51.	Dr. Nahid Ahmed Chowdhury	ASRH/FP Advisor	NHSDP
52.	Babul Adhikary	Program Coordinator	PIACT Bangladesh
53.	Mohiuddin Ahmed	Sr. Communication Specialist	BKMI
54.	Md. Moniruzzaman Bipul	Project Manager, MIYCN	GAIN
55.	Dr. Subir Khiang Babu	Program Manager, UBR	RH-STEP

Inter-ministerial Committee

1.	Additional Secretary, Ministry of Health & Family Welfare	Chairperson
2.	Additional Secretary (FW & Prog), Ministry of Health & Family Welfare	Member
3.	Director General, Directorate General of Family Planning	Member
4.	Joint Chief (Planning), Ministry of Health & Family Welfare	Member
5.	Representative, Ministry of Women and Children Affairs	Member
6.	Representative, Ministry of Youth & Sports	Member
7.	Representative, Ministry of Education	Member
8.	Representative, Ministry of Information	Member
9.	Representative, Ministry of Social Welfare	Member
10.	Representative, Local Government Department	Member
11.	Representative, Ministry of Law, Justice and Parliament Affair	Member
12.	Representative, Ministry of Homes	Member
13.	Representative, Ministry of Religious Affairs	Member
14.	Representative, DGHS	Member
15.	Line Director, MCRAH OP, DGFP	Member
16.	Deputy Chief (Health / FW)	Member Secretary

