



GAGE Digest
**Policy and
legal analysis
notes: Bangladesh**

A review of the
National Strategy
for Adolescent Health

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Introduction

In Bangladesh, about two-thirds of young women marry before the legal age of marriage (18 years). Many also become adolescent mothers: 5.3% of 15-year-old girls have had a live birth, rising to 12.4% among 16-year-olds, and by the age of 19, more than half of adolescent girls have had a live birth (National Institute of Population Research and Training (NIPORT), 2016). The 2015 Bangladesh Bureau of Statistics (BBS) survey shows that physical and sexual violence are prevalent among ever married women, including the 15–19 age group (Ministry of Planning, 2016). These statistics indicate the need for a comprehensive sexual and reproductive health (SRH) policy framework and strategy for adolescents in Bangladesh.

To understand the policy context for adolescent health, wellbeing and bodily integrity, we reviewed the National Strategy for Adolescent Health 2017-2030 (known as NAHS) and its predecessor, the National Adolescent Reproductive Health Strategy (NARHS) 2006. We reviewed both as NAHS was developed after NAHS lapsed and NAHS played an important role in bringing adolescent issue into the Sexual and reproductive rights discourse in Bangladesh. We aimed to: (a) identify the key actors involved in policy formulation; (b) analyse the nature of the contextual shifts that have influenced the policy space (positively or negatively); (c) explore the nature of various forms of resistance encountered during the process of drafting the policy; and (d) illustrate some of the implementation challenges encountered.

We used a political economy lens to explore these issues, which allows for identifying who the key actors are, which contextual factors influence policy bargaining processes, the interests of different actors in promoting policy change, and how issues are framed to justify the changes demanded. To develop a full picture of the strategy adoption process, the research team used historical process tracing methodology. Research activities included mapping the relevant stakeholders (actors), developing a timeline of the strategy, reviewing secondary documents and identifying key informants using a snowballing method. Interviewees included ministry officials, staff from national and international non-governmental organisations (NGOs), donors, academics and policy experts hired specifically for drafting the strategy.

This note provides a brief summary of our findings. We draw some conclusions on the usefulness of political economy analysis for understanding the politics and

complexities of policy and legal change, and reflect on how this approach can support the Gender and Adolescence: Global Evidence (GAGE) research programme and programming more broadly.

The story of the strategy

Contextual factors

The policy discourse in Bangladesh on adolescent sexual and reproductive health (SRH) has been influenced by various contextual factors. First, the demographic transition has produced a one-time 'demographic dividend', providing an excess of working-age population over the dependent population, and there is interest among policy circles in how best to take advantage of it. Second, girls marry – and get pregnant – at a young age; knowledge of and access to contraception, and girls' reproductive health, are thus key concerns. Policy-makers are increasingly aware of key areas that need attention, from nutrition, mental health, basic hygiene and sanitation (including menstrual hygiene), to cyber violence, harassment and substance abuse. Violence against women and girls is also recognised as a major problem, with younger girls more susceptible to abuse and harassment at home, at school, on the streets, and in public institutions.

How did the strategy evolve?

In Bangladesh, interest in adolescent health began as part of initiatives to control population growth and reduce maternal and child mortality. A more rights-based approach emerged from the International Conference on Population and Development (ICPD) in Cairo in 1994, which recognised SRH rights and the role of government, NGOs and international agencies in realising these rights. Responding to advocacy from national and international NGOs and international development partners, the government decided to develop an adolescent reproductive health strategy, with assistance from the United Nations Population Fund (UNFPA). In 2003 it organised a National Conference, which formed a National Steering Committee for Adolescent Health Strategy. The Directorate General of Family Planning (DGFP) within the Ministry of Health and Family Welfare initiated the process of drafting the first national strategy, which was finalized in 2006, with technical and financial support from UNFPA, bilateral donors and experts in the field.

The strategy formulation process was open and received inputs and feedback from workshops attended by civil society organisations (CSOs) and networks, doctors and health-care professional and media representatives. The government was not willing to directly address sexual health but was willing to address reproductive health.

The NARHS (2006) had six strategic objectives, with subsections and multiple priority activities under each, and identifying which ministries would play a key role in implementation. The objectives sought to improve adolescents' knowledge of reproductive health issues, create a positive environment in the community, reduce incidence of early marriage and pregnancy, reduce prevalence of sexually transmitted illnesses (STIs) and discourage risky behaviours. While the strategy was formulated relatively quickly, implementation was marred by delays. Indeed, the action plan for implementing the NARHS was only finalised in 2013 – three years before the strategy was due to expire – due to inner wrangles, poor coordination and lack of funding. The Ministry/DGFP and other development partners started drafting the successor strategy early enough for the implementation plan to be formulated with sufficient time.

Other factors also influenced thinking around the new strategy. The government was keen to tap into the 'demographic dividend', while issues such as early marriage and pregnancy were gaining more attention, especially as they could reduce the gains from any such dividend. Given these factors, and Bangladesh's progress towards achieving the Millennium Development Goals (MDGs) (particularly on maternal health), senior policy circles looked to adolescent health as a key area to focus on. Reflecting this, in 2010, at a UN Summit, the country's prime minister committed to address this issue.

Another factor driving the need for a broader policy was that different United Nations (UN) agencies and government institutions were developing programmes for adolescents but with little coordination. This highlighted the need for the state and donors to coordinate their efforts to develop a comprehensive strategy for adolescent health. This led to the decision to involve the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and UNFPA from the beginning, as well as the government's DGFP and the Directorate General of Health Services (DGHS). UNICEF focused on rights-based issues,

UNFPA provided technical advice on reproductive health, and WHO focused on costing the strategy. The NAHS was formulated to be aligned with the timeline (up to 2030) for the Sustainable Development Goals (SDGs).

What does the strategy cover?

There was a clear recognition among all policy actors that adolescents' health needs are multidimensional, that they need access beyond primary health care, and that girls and boys alike do not have enough information (if any) on sexual and reproductive health. There was also recognition that adolescents are particularly vulnerable to violence in a range of settings, from their homes and schools to the workplace and other public spaces. The gap in service provision for vulnerable groups such as adolescents with disabilities, those living in urban slums and in hard-to-reach areas were also expressed as a key concern.

Given the broad consensus that existed, the new strategy was able to reflect adolescents' changing needs. The current strategy has four strategic directions (SDs): (1) all aspects of adolescent SRH; (2) violence against adolescents; (3) adolescent nutrition; and (4) mental health. Each SD starts off with a brief problem statement followed by a description of the context, then identifying key objectives and key strategies to achieve them. The NAHS also has two cross-cutting issues, focusing on social and behaviour change communication (SBCC) and health systems strengthening. The strategy document has a final section entitled 'vulnerable adolescents in challenging situations' but only identifies a list of key strategies for this specific group.

The NAHS (2017–2030) maintains continuity with the previous strategy by emphasising the need to improve health care services for adolescents across the country as well as the need to bring about changes within communities. It includes objectives to improve education curricula as a means of raising awareness among adolescents and teachers. Capacity building and improving health service delivery are also identified as key areas. It differs from the previous policy in that it includes specific objectives to improve adolescent nutrition and mental health, as well as adolescents' SRH. Finally, it focuses on improving data collection for better evidence-based planning, citing the need for political commitment to bring about change.

Key findings

Our political economy analysis reveals the following key findings.

- The relative power balance between key policy actors driving the NAHS (state agencies, donors and CSOs) has shifted over time. While CSO alliances were more powerful during the strategy formulation phase of the 2006 policy (reflecting more open policy space at that time), the influence of national organisations and rights-based international NGOs has declined. Currently, CSOs are restricted to providing technical support and collaborating with the government on implementation. This lesser voice of national organisations is mirrored in fewer channels for holding government to account on implementation of the strategy.
- The key champions within government were the Ministry of Health, the DGFP and DGHS. Within these institutions individual champions played a key role in sustaining the strategy adoption and the development of an implementation plan. However as these individuals have been transferred to other departments or retired the absence of these individuals may pose a risk for the implementation of the strategy. Lack of coordination between DGFP and DGHS could hamper implementation, as might lack of coordination between the ministries of Health and Education on the reproductive health education content (the latter fearing a backlash from religious quarters). Another potential challenge is that the Ministry of Health does not have a mandate to implement programmes in urban areas as these fall under the Local Government Division, although that institution is supposed to adopt Ministry of Health policies.
- International discourses and ideas (particularly around the ICPD, the Beijing Conference and the MDGs) played a key role in opening up and influencing the policy space on adolescent health in Bangladesh, and the current policy and strategy closely matches the SDG 2030 agenda. However, the strategy was also influenced by ideas of national development and the drive to create a modern nation, reflecting strong intentions to take advantage of the demographic dividend and the need to keep fertility rates down given rates of early marriage.
- International NGOs and UN agencies played a key role in pushing for a focus on adolescent issues, with UNFPA closely involved in formulating the NARHS 2006, and UNFPA, UNICEF and WHO involved in developing the current NAHS. The recognised need for strong coordination led to wider collaboration and created space for donors to contribute to shaping the new strategy – though donor influence on more contentious issues (such as sex education or access to contraception for unmarried adolescents) is limited. This also reflects the changed power dynamics in that as Bangladesh moves towards becoming a middle-income country, national policy-makers may be less amenable to taking on policy suggestions from international donors and UN actors.
- While the rhetoric and content of the current strategy is inclusive, and the policy touches on the diversity of adolescents' needs – whether they are in urban or rural settings, have a disability, belong to hard-to-reach groups or other vulnerable groups – implementation is likely to face many challenges. These include: (a) lack of coordination between ministries and departments; (b) funding gaps, reflecting shifting donor priorities; (c) staff capacity and challenges in meeting diverse needs; and (d) conservatism inside the state or fear of a backlash due to providing services such as contraceptives or menstrual regulation (used in lieu of abortion services) to unmarried adolescents. On this point, it is hard to gauge opposition to the strategy from external actors. While there have been no public demonstrations or protests against the strategy, given its technical nature, the recent rise of religious groups and their influence in politics means that the possibility of staunch opposition needs to be taken into account. Compared to the level of need among different groups of adolescents, the attempts to design specific measures appear somewhat limited. However, Bangladesh's health infrastructure is extensive and goes down to the union and even village level, with the community clinics. However, the issue of adolescents' access to these services has always been problematic given conservative social norms, poor delivery of services and poor planning and coordination within state agencies; and these problems still remain.

Conclusion

The above discussion highlights the ways in which the bargaining between actors that underpinned the current National Adolescent Health Strategy in Bangladesh is likely to create difficulties in implementing the strategy, despite its inclusive rhetoric and ambitious agenda. What do these findings mean for future research, practice and programming on adolescent health?

- The frequent references to international discourses and commitments made by the national government (to the MDGs, SDGs, etc.) indicates that framing research findings and recommendations within the context of international commitments and conventions may be useful to facilitate buy-in from policy-makers.
- Addressing issues such as child marriage, violence, and sexual rights by linking these to instrumental framing or as a means of attaining other political goals has been seen to be a successful strategy and could be used in future. The government has prioritised this issue from an instrumental perspective, seeing adolescents as a group whose needs should be met given their potential to contribute to national development. However, there is an opportunity and a need to complement this perspective with a rights-based approach, which would prioritise the interests and needs of adolescents themselves. While the NAHS itself is expansive and covers diverse issues, it pays little attention to developing adolescents' agency. The framing of the strategy also remains conservative in its approach in relation to bodily integrity and SRH rights. This perhaps reflects the social conservatism that exists within national policy circles but also the political reality whereby conservative forces have gained ground. Given this context, instrumental framing of adolescents' needs in programming may help avoid controversy.
- The fact that there are evidence gaps and few targeted services in some emerging areas of concern (e.g. mental health, substance abuse, urban slum dwellers,

and unmarried adolescents) presents opportunities for research programmes to provide the necessary evidence.

- While government resources have increased and it can finance larger shares of its developmental activities, there is still a tendency to seek external support and funding for issues considered 'secondary'. Although the government has used its own resources for adolescent service provision in urban areas, this was financed through UNFPA, and changes in that agency's strategy mean the funding was discontinued and activities have stopped. Development partners will therefore need to be strategic in harnessing and complementing existing funding sources.
- As the space for critiquing government actions shrinks, this may affect what issues are raised when it comes to adolescent health. The more critical voices of rights-based and feminist organisations – with alternative views on adolescent health, reproductive health, sexuality and other issues – are not being given space within national policy circles. This means that discussions have shifted to more technical aspects of the strategy. There is room for interactions with the state by actors who have been able to convince the government of their credentials and technical expertise.

This political economy analysis has shown that the policy space in Bangladesh and, indeed, CSO alliances have changed over recent years. Development programmers and researchers will have to think strategically about how to present their activities in the Bangladeshi landscape and which groups or individuals they choose as allies. The influence of rights-based actors is slowly declining, given the narrowing civil society space, such that critiques are not welcome. But there is space to provide technical help. Development actors need to think strategically about how they want to position themselves in framing the issues around adolescent capabilities and rights when interacting with the state.

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About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org.uk for more information.

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