VERY YOUNG ADOLESCENTS IN BANGLADESH

A Review Of Social And Behavior Change Programs Addressing Adolescent Childbearing

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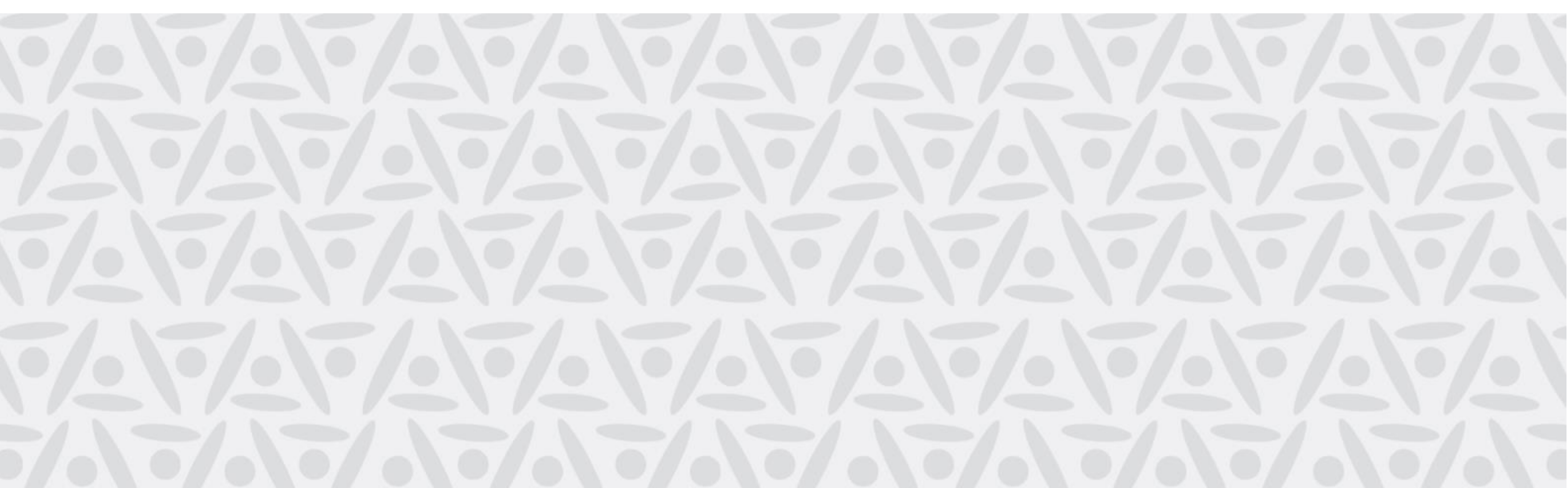

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ACRONYMS

AI	Artificial intelligence
ASRH	Adolescent Sexual and Reproductive Health
AUAFP	Accelerating Universal Access to Family Planning
BDHS	Bangladesh Demographic and Healthy Survey
BHE	Bureau of Health Education
BLOOM	Better Life Options and Opportunities Model
CBOs	Community Based Organizations
CCG	Core Consultative Group
CHT	Chattogram Hill Tracts
CHWs	Community Health Workers
CORO	Committee of Resource Organizations (for Literacy)
COVID/COVID-19	Coronavirus Disease/Coronavirus Disease 2019
CRMA	Child Marriage and Restraint Act
CSE	Comprehensive Sexuality Education
DEC	Development Experience Clearinghouse
DESA	Department of Economic and Social Affairs
DGFP	Directorate General of Family Planning
DSHE	Directorate of Secondary and Higher Education
DSS	Department of Social Services
FP	Family Planning
GAGE	Gender and Adolescents: Global Evidence
GB	Generation Breakthrough
GBV	Gender-Based Violence
GEAS	Global Early Adolescent Study
GEMS	Gender Equity Movement in Schools
GoB	Government of Bangladesh
HCD	Human-Centered design
HIES	Household Income Expenditure Survey
HNPSP	Health, Nutrition and Population Sector Program
ICRW	International Centre for Research on Women
IEM	Information, Education and Motivation
IEC	Information, Education, Communication
IGA	Income generating activities
ILO	International Labor Organization
I/NGO	International/Nongovernmental Organization
MCH	Maternal and Child Health
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MoSW	Ministry of Social Welfare

MoWCA	Ministry of Women and Children's Affairs
NCTF	National Children's Task Force
NEARS	Network for Ensuring Adolescent Reproductive Health, Rights and Services
NNPC	Nari Nirzaton Protirodh Committee
NSAH	National Strategy for Adolescent Health
OPHN	Office of Population, Health and Nutrition
PLOS	Public Library of Science
PRB	Population Reference Bureau
RTM	Research, Training and Management
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SDGs	Sustainable Development Goals
SEM	Socio-Ecological Model
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TISS	Tata Institute for Social Sciences
UN	United Nations
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VYA	Very Young Adolescent
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

INTRODUCTION

Persistently high rates of adolescent childbearing contribute to poor economic, social, and health outcomes among adolescent girls and their communities. The World Health Organization (WHO) estimates that each year, 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million of them give birth. Data on childbirth among girls aged 10–14 (commonly called very young adolescents; VYAs) are becoming more widely available. Guttmacher found that VYA females in developing regions had an estimated 777,000 births in 2016; 58 percent of these births took place in Africa, 28 percent in Asia, and 14 percent in Latin America and the Caribbean. Slightly more than one-third of births to mothers younger than 15 in developing countries were unplanned. (1) The United Nations (UN) Department of Economic and Social Affairs (DESA) reports elevated levels of early adolescent fertility in 11 countries in sub-Saharan Africa and one country in Asia (Bangladesh). Adolescent mothers face higher risks of eclampsia, puerperal endometritis, systemic infections, and maternal mortality than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth, and infant mortality.(2) Preventing pregnancy among adolescents and pregnancy-related mortality and morbidity are foundational to achieving positive health outcomes across the life course and imperative for achieving the Sustainable Development Goals (SDGs) related to maternal and newborn health.

The Government of Bangladesh (GoB) aspires to delay all childbearing to at least the age of 20, but Bangladeshi adolescents aged 10–19 continue to experience pregnancy and childbearing. According to the 2022 Bangladesh Demographic and Health Survey (BDHS) Key Indicators Report[1], 47.5 percent of 19-year-old adolescents and 4.9 percent of 15-year-olds have ever been pregnant. (3) VYAs are particularly vulnerable to the multiple health risks of early pregnancy and childbearing, with global evidence suggesting that VYAs face a higher risk of maternal mortality than older adolescents and young adults. (1,4)

Using evidence-based social and behavior change (SBC) approaches that engage VYAs, their families, communities, and systems can contribute to delaying very early childbearing among VYAs and lay the foundation to enable adolescents to delay childbearing as they age into later adolescence. However, little is known about the current state of SBC programming with and for VYAs in Bangladesh. To address this gap and to support the priorities of the GoB as articulated in the National Strategy for Adolescent Health 2017-2030 and National Action Plan to End Child Marriage 2018-2030, the United States Agency for International Development (USAID) Bangladesh requested the Agency for All project[2] to conduct a series of activities to synthesize and curate learning on VYA SBC programming that contributes to reducing adolescent childbearing in Bangladesh. To inform the development of a set of actionable recommendations for strengthening SBC programming, Agency for All has documented the following:

- Factors that drive adolescent childbearing in Bangladesh
- Landscape of SBC programming with VYAs that aim to contribute to reducing adolescent childbearing
- Ecosystem of local organizations addressing these issues in Bangladesh

[1] This report uses data from the 2022 Bangladesh Demographic and Health Survey Key Indicators Report where available. Where 2022 data is not available, the report cites data from the 2017-2018 BDHS.
[2] Agency for All is a five-year (2022-2027) USAID-funded project led by a consortium of diverse research and implementation organizations with a mission to generate evidence on the role of agency in effective social and behavior change programming to improve health and well-being for individuals and communities. Agency for All works to advance cross-sector development outcomes, including family planning and reproductive health; maternal, newborn, and child health; nutrition; infectious disease; and HIV/AIDS.

METHODOLOGY

The Agency for All team conducted a review of the current state of the field of SBC programming with and for VYAs to address adolescent childbearing in Bangladesh. The review, conducted between October 2022 and June 2023, consisted of a synthesis of currently available evidence through a comprehensive scan and curation of literature and documentation; key informant interviews with stakeholders in Bangladesh with expertise in VYAs, adolescent childbearing, and related topics such as child marriage; an organizational mapping of nongovernmental organizations (NGOs) implementing programs to address adolescent pregnancy or its related drivers; community consultations in all eight divisions of Bangladesh; and a series of "Solutions Workshops" to engage a wide range of stakeholders in arriving at programmatic recommendations. All research activities were designed to be iterative—informed by, and built upon, the previous activity.

Engagement of Stakeholders

To ensure input from key stakeholders was taken into account throughout the process, Agency for All convened a group of national stakeholders and experts. This Core Consultative Group (CCG) consisted of representatives from the GoB, NGOs, civil society, academia, as well as adolescents and youth (see Annex 1). The CCG met periodically throughout the research period to provide input on the scope of the research and the design for each stage of the research; to review and provide feedback on preliminary findings; and to provide advice to improve the relevance of the research activities, findings, and recommendations.

Scope

This research follows the USAID and WHO definitions of adolescents as inclusive of ages 10–19, with VYAs defined as adolescents aged 10–14. As such, this review primarily focused on SBC initiatives that aimed to reach VYA girls and boys aged 10–14, as well as the family members and community members with influence over VYA girls' reproductive decision-making and/or child marriage (as a primary driver of adolescent childbearing). However, given the paucity of programs designed to directly engage with this age group and limited availability of data on specific age ranges addressed by programs engaging "adolescents," the review also captured programs addressing the broader 10–19-year-old adolescent age range. This review is national in scope, and specific efforts were made in each research activity (i.e., literature review, key informant interviews, mapping, consultations, and workshops) to understand the drivers of adolescent childbearing and the challenges to reducing it given the multiple variables that support the practice.

Synthesis of Existing Literature

Agency for All conducted a synthesis and curation of existing evidence and program documentation (both peer-reviewed and grey literature) on SBC interventions and/or research addressing adolescent childbearing, including programs addressing child marriage. The intention of this literature scan was to build on, rather than replicate, a 2017 evidence review and situation analysis by Population Council as part of the USAID-funded Evidence Project, which reviewed articles and grey literature published between 2005 and 2015. (5) Agency for All also reviewed global reviews on VYA programming with the aim of identifying evidence-based recommendations for VYA SBC programs and grounding the Bangladeshi literature in the global landscape. (1,6–12) The CCG was consulted on the literature scan protocol and gave input on the inclusion criteria, search strategy, key words, and analysis approach.

Inclusion Criteria

Agency for All used the following inclusion criteria to search for and filter documentation from both peer-reviewed sources and grey literature, such as program documentation and reports:

- Published between 2016 and 2022 to build on the Evidence Project situation analysis, which covered 2005-2016
- Described, documented, and/or evaluated an SBC intervention addressing adolescent childbearing or related issues and drivers, including reproductive health information and services, pregnancy prevention, and child marriage
- Referred to an intervention intending to reach VYA girls and/or boys aged 10–14 and/or community members who wield influence over VYAs (Given the paucity of available literature on this specific age group, the review was expanded to also include all adolescents 10–19, while keeping special attention on the 10–14 age range.)

The review was restricted to English language sources that address interventions or research conducted in Bangladesh.

The review considered sources from the reproductive health sector, from other health areas that have potential reach to VYAs (e.g., mental health or nutrition), and from other sectors that include programming for VYAs that could affect adolescent childbearing, such as education, humanitarian, poverty reduction, and livelihoods.

Search Strategy

The literature review was based primarily on literature obtained through searches of online databases including Google, Google Scholar, PubMed, Gates Open Research, Public Library of Science (PLOS), USAID's Development Experience Clearinghouse (DEC), and SBC professional knowledge management platforms, Communication Initiative and Springboard. A search for program documentation was also conducted through the websites of 26 organizations known to be implementing programs and/or research with adolescents in Bangladesh.

The following key words were used in various combinations with the "and" operator in the search:

- Populations of interest: very young adolescents, adolescents
- Outcomes of interest: pregnancy prevention, delay of first pregnancy, contraceptive use, adolescent childbearing, early/child/forced marriage, reproductive health
- Reproductive health programmatic terms: comprehensive sexuality education, life skills development, reproductive health education, gender transformative, empowerment, agency
- SBC terms: behavior change, social behavior change, behavioral insights, gender norms, social norms, normative change
- Geographic location: Bangladesh

The literature review identified 22 documents (peer-reviewed and grey literature) published between 2016 and 2022 that specifically discussed efforts to address adolescent childbearing and child marriage. The literature discussed these topics as it relates to improving adolescent access to sexual and reproductive health (SRH) information and developing key life skills and/or creating family and community awareness of and support for preventing child marriage and adolescent childbearing (see Annex 2 for a list of sources

reviewed). Each document was reviewed to extract key information, including project goals and objectives, geographic locations of project activities, target populations/beneficiaries, SBC approaches and platforms, evaluation activities, and findings (see Annex 3 for a summary of programmatic information gathered in the literature review).

Key Informant Interviews

A total of fifteen key informant interviews were conducted with stakeholders in a position to provide expert views on VYAs, the drivers of adolescent childbearing in Bangladesh, and/or programmatic responses addressing adolescent childbearing. The interviews consisted of a 60-minute semi-structured set of questions exploring respondents' views on drivers of adolescent childbearing in Bangladesh, current SBC practices used to address them, what is working, what the gaps are, and emerging challenges and trends. Respondents represented government, NGOs, and research institutions engaged in policy, programming, and/or research on adolescent sexual and reproductive health (ASRH), family planning (FP), child marriage, and adolescent childbearing. Respondents were selected based on a list of potential respondents developed through the literature review as well as Agency for All's and USAID's knowledge of organizations and networks working in this space, with input and validation from the CCG (see Annex 4 for a list of key informant interview respondents).

The key informant interviews were conducted in the final stages of the literature review but prior to conclusion of the literature review. In this way, interviews could be used to corroborate findings and explore gaps from the literature review, including emerging and evolving drivers that may not yet be captured in written documentation. In cases where informants pointed to documentation or references not already captured in the literature review, these sources were then included in the final stages of literature review.

Common themes were identified across the interviews, and then informant responses were categorized by the identified themes. Respondent data was de-identified and presented to the CCG for their reflections and input on analysis and synthesis.

Organizational Mapping

Agency for All conducted a mapping of local organizations that work with adolescents (including VYAs) in Bangladesh to prevent adolescent childbearing and related issues. The mapping built upon the findings from the literature review and key informant interviews, with the aim of providing further insights into opportunities and capacities for SBC programming for VYAs, especially to address key drivers of adolescent childbearing.

Listing and Search Strategy

Agency for All began by generating a list constituting the "universe" of local NGOs (i.e., NGOs not part of a multi-country or international entity) that address adolescent childbearing or related drivers in their mandate. This list was generated by: 1) listing organizations known to Agency for All and USAID; 2) cross-referencing with organizations mentioned in sources from the literature review, as well as organizations mentioned in the key informant interviews; and 3) internet searches to identify additional organizations not captured above. The intention of this review was to understand local NGO coverage and capacities around SBC with VYAs to prevent adolescent childbearing. Hence, the review did not include multilateral

organizations or international nongovernmental organizations (INGOs). This search resulted in a list of 58 organizations (see Annex 5 for a summary of each organization's mandate and coverage).

Mapping Interviews

From this list, Agency for All selected a sub-sample of organizations with which to conduct a set of mapping interviews to seek further details on their coverage areas, programmatic focus, and capacities. This sample was purposely selected to represent different geographies and programmatic focus. Additional organizations were identified during the interviews through snowball sampling, as the respondents were asked to identify other organizations implementing programs for adolescents and/or VYAs to address adolescent childbearing and/or child marriage.

Interviews were conducted with either SBC program officers/managers or relevant project or activity leads for adolescent programming from each of the shortlisted organizations. Interviews followed a semi-structured format based on an interview guide designed to understand the topics, ages, and geographies covered by the organizations' programs most relevant to adolescent childbearing, as well as the SBC approaches employed and organizational capacity needs. Common themes were identified across the interviews, and then informant responses were categorized by the identified themes.

Community Consultations

Agency for All conducted community consultations with VYA girls and boys and adults with influence over adolescent lives. The development of the thematic questions for the consultations was informed by the evidence gathered during previous research activities (i.e., the literature review, key informant interviews, and organizational mapping interviews). These consultations sought to explore an area that was less understood and documented—specifically, which SBC strategies were likely to be more or less useful in engaging community members (including both peers and adults) that influence and/or make decisions around childbearing and marriage for this age group.

Agency for All conducted four "Solutions Workshops" to engage a diverse set of national stakeholders around the findings from these research activities and co-create recommendations for improving SBC programming for VYAs. The recommendations address issues of delaying childbearing, identifying new approaches to engaging communities around this issue, and suggest improvements to structures and capacities that support quality SBC programs to address the drivers of early childbearing.

Consultation Design

The community consultations used age-appropriate participatory and projective methodologies, such as vignettes, vision mapping, sorting, and dot voting to elicit participant insights and recommendations. The activities used in the consultations are summarized in Table 1.

Table 1: Community Consultation Activities

Community Groups	Activity	Purpose
Adult community members	Group Brainstorming	List factors driving adolescent childbearing in their community
	Vision Map	Identify solutions/strategies for addressing adolescent childbearing and its causes, and which actors can play what role in the solutions
	Picture Sort/Dot Voting	Identify which SBC intervention channels are preferred for receiving information/support related to preventing adolescent childbearing
VYAs (boys and girls)	Vignette/Complete the Story (different vignettes for boys and girls)	Identify strategies and interventions VYAs feel would be most helpful in preventing adolescent childbearing Explore SBC program design recommendations based on what VYAs need to know, feel, and do to prevent adolescent childbearing
	Influencer Ranking	Identify and prioritize influential people and pathways for shaping norms and behavior change
	Picture Sort/Dot Voting	Identify which SBC intervention channels are preferred for receiving information/support related to preventing adolescent childbearing

Consultation Locations & Participants

A total of 36 community-level consultations were conducted. Each consultation included 10–12 participants. Three consultations (one each with VYA girls, VYA boys, and one mixed-sex group of adults who have influence over VYAs) were held in each of the eight geographical divisions of Bangladesh. In each division, consultations were conducted in the district with the highest prevalence of adolescent childbearing (based on data from the Multiple Indicator Cluster Survey [MICS] 2019). (13) In most cases, these were also the districts with the highest prevalence of child marriage. In addition to the initial set of consultations conducted in these districts (24 in total), Agency for All conducted 12 consultations with urban slum community members in Dhaka, plainland ethnic minority communities in the Chapai Nawabganj district, and Bengali and ethnic minority community members from the host communities impacted by the influx of Rohingya refugees in the Cox's Bazar area to ensure that the perspectives of these highly vulnerable communities were reflected in the findings and recommendations. The variation in sites allowed for exploration of contextual vulnerabilities and variations specific to different locations and communities.

In total, 287 VYAs (aged 10–14) and 147 adults (aged 25 and over) participated in the 36 consultations. Efforts were made in recruitment to ensure an equal mix of both rural and urban dwelling participants, as well as married and unmarried VYAs (for the girls' groups) and balanced representation of men and women (for the mixed-sex adult groups). Adults were also purposely sampled to represent a mix of parents/in-laws of VYAs, professionals that work with the VYA age group (e.g., schoolteachers, health care providers that serve adolescent clients, staff of youth-serving organizations), and community leaders that interact with or have influence over the VYA demographic (e.g., religious leaders, local elected officials, local law enforcement officials, etc.). Table 2 provides an overview of the selected districts within each division, the

prevalence of adolescent childbearing and early marriage, and the contextual conditions that each site allowed Agency for All to investigate in this research.

Table 2. Consultation locations and prevalence of adolescent childbearing and child marriage, MICS 2019

Division	District	District prevalence of childbearing before 18 (%) (MICS 2019)	District prevalence of child marriage (%) (MICS 2019)	Specific contextual risk factors
Dhaka	Manikganj	30.8	62.8	District with highest adolescent childbearing in the division
Dhaka	Dhaka	21.6	41.0	Vulnerable urban slum characterized by limited access and opportunities
Mymensingh	Sherpur	29.9	64.0	District with highest adolescent childbearing in the division; border district (India)
Chattogram	Brahmanbaria	27.7	46.5	District with highest adolescent childbearing in the division
Chattogram	Cox's Bazar	24.7	36.6	Unique challenges and vulnerabilities posed by the influx of the Rohingya refugees *Note: separate sets of consultations conducted with Bengali and ethnic minority community members of the host community*
Rajshahi	Chapai Nawabganj	53.6	72.9	District with highest adolescent childbearing in the division; border district (India); popular and large trade hub presents risks for drugs, trafficking, illegal migration, etc. *Note: separate sets of consultations conducted with both mainstream community and plainland ethnic minority community*
Rangpur	Gaibandha	35.5	62.0	District with highest adolescent childbearing in the division; climate-vulnerable area, prone to flooding, river erosion; hard-to-reach riverine *char* lands[3]
Khulna	Narail	41.6	71.0	District with highest adolescent childbearing in the division
Barishal	Barishal	23.5	49.3	District with highest adolescent childbearing in the division
Sylhet	Sunamganj	22.4	41.9	District with highest adolescent childbearing in the division; prone to flash floods; hard-to-reach area surrounded by *haors*

[3] A char is land surrounded by the water, usually an accretion of sand/soil which create opportunities to establish settlements and pursue agricultural activities.

All data was collected anonymously, and no direct quotes or other identifying data were retained. The consultation team met after each set of consultations to agree on the themes emerging. Responses, insights, and recommendations for each theme were then grouped and tallied for each group (i.e., separately for girls, boys, and adults). Notes from each subsequent session were then synthesized with notes from previous sessions to create a cumulative list of themes and findings across all the consultations for each of the three demographic groups.

Solutions Workshops

Agency for All conducted four "Solutions Workshops" to engage a diverse set of national stakeholders with the findings from these research activities and co-create recommendations for improving SBC programming for VYAs. The recommendations address the issues of delaying childbearing, identifying new approaches to engaging communities around this issue, and suggest improvements to structures and capacities that support quality SBC programs to address the drivers of early childbearing.

Workshop Purpose and Design

The purpose of the workshops was to build on the insights gathered from previous research activities to generate evidence-informed and culturally appropriate draft solutions for the development of VYA-specific SBC programs that have the potential to reduce adolescent childbearing in Bangladesh.

The workshop design incorporated human-centered design (HCD) approaches to focus participants on actionable and specific solutions. Following a presentation of research findings, workshop participants worked in facilitated groups using HCD-inspired techniques to frame problems or challenges in a way that encouraged creative, solutions-oriented thinking and systematic problem solving. This was followed by plenary discussion and a facilitated prioritization exercise to identify recommendations that participants felt were most likely to lead to impact.

Workshop Participants

Four workshops of 25–30 participants each were held with the following groups:

1. Representatives of youth-led and adolescent organizations/networks/platforms, including non-registered adolescent and youth groups
2. Local duty-bearers and civil society members identified through the community consultations with VYAs as the most influential in impacting decision-making related to early marriage/childbearing (e.g., schoolteachers, religious leaders, *kazi*/marriage registers, community-level health practitioners, journalists, union parishad chairman/members, community support groups, members of Child Marriage Prevention Committee, etc.)
3. I/NGOs, development partners, and UN agencies with mandates to address VYAs and/or with programming addressing adolescent childbearing and/or its related drivers (e.g., child marriage)
4. GoB representatives from relevant line ministries and directorates with mandates to address aspects of adolescent and youth health and development

The first workshop was designated as an adolescent/youth-friendly space to ensure a safe space for full adolescent and youth participation. There was also youth and adolescent/organization representation in the workshops with I/NGO and government representatives. Special effort was also made for translation

and other supports to enable participation of ethnic minority communities from the plainland and Chittagong Hill Tracts (CHT) in the Solutions Workshops.

Analysis (cross-activity synthesis)

Analysis was iterative, with each activity informing the next. The literature review findings informed the development of questions for semi-structured key informant interviews. The literature findings and key informant interviews were then synthesized into a preliminary set of insights which were used to identify themes and gaps for further exploration in both the organizational mapping and the community consultations. Analysis of both activities was then used to refine and elaborate on the preliminary insights and draft recommendations. The resulting five key insights were shared and validated in the Solutions Workshops. In Solutions Workshops participants engaged in HCD-style activities to co-create solutions and recommendations arising from these insights. The recommendations generated in the workshop were then used to update and expand upon the draft recommendations. Following the workshop, the initial five insights were also reformulated into the nine insights that appear in this report. The CCG provided feedback on the design of data collection tools and contributed to the validation of findings and synthesis of insights from each stage of the analysis, as well as to the resulting recommendations.

FINDINGS

The Global Context of VYA SBC Programming

There is growing global interest in VYA SBC programming to improve reproductive health and gender outcomes.

A growing interest in programming and research related to VYAs has emerged over the last 15 years. This age group experiences the second most significant period of rapid brain development after the first 1,000 days of early childhood and immense physical and socio-emotional changes as they go through adolescence. (1,14) At the same time, evidence from the Global Early Adolescent Study (GEAS) and other research finds that VYAs progressively experience constraints and expectations rooted in gender inequality—with girls increasingly seen as ready for marriage and childbearing and boys expected to take on financial and other household burdens. (4) This confluence of changes presents a unique opportunity for intervention. By intervening with VYAs early, there is an opportunity to improve gender attitudes, behaviors, and norms before they are firmly entrenched; support positive social and emotional development; improve reproductive health knowledge and behaviors; and potentially contribute to delaying child marriage and preventing adolescent pregnancy and childbearing. (2)

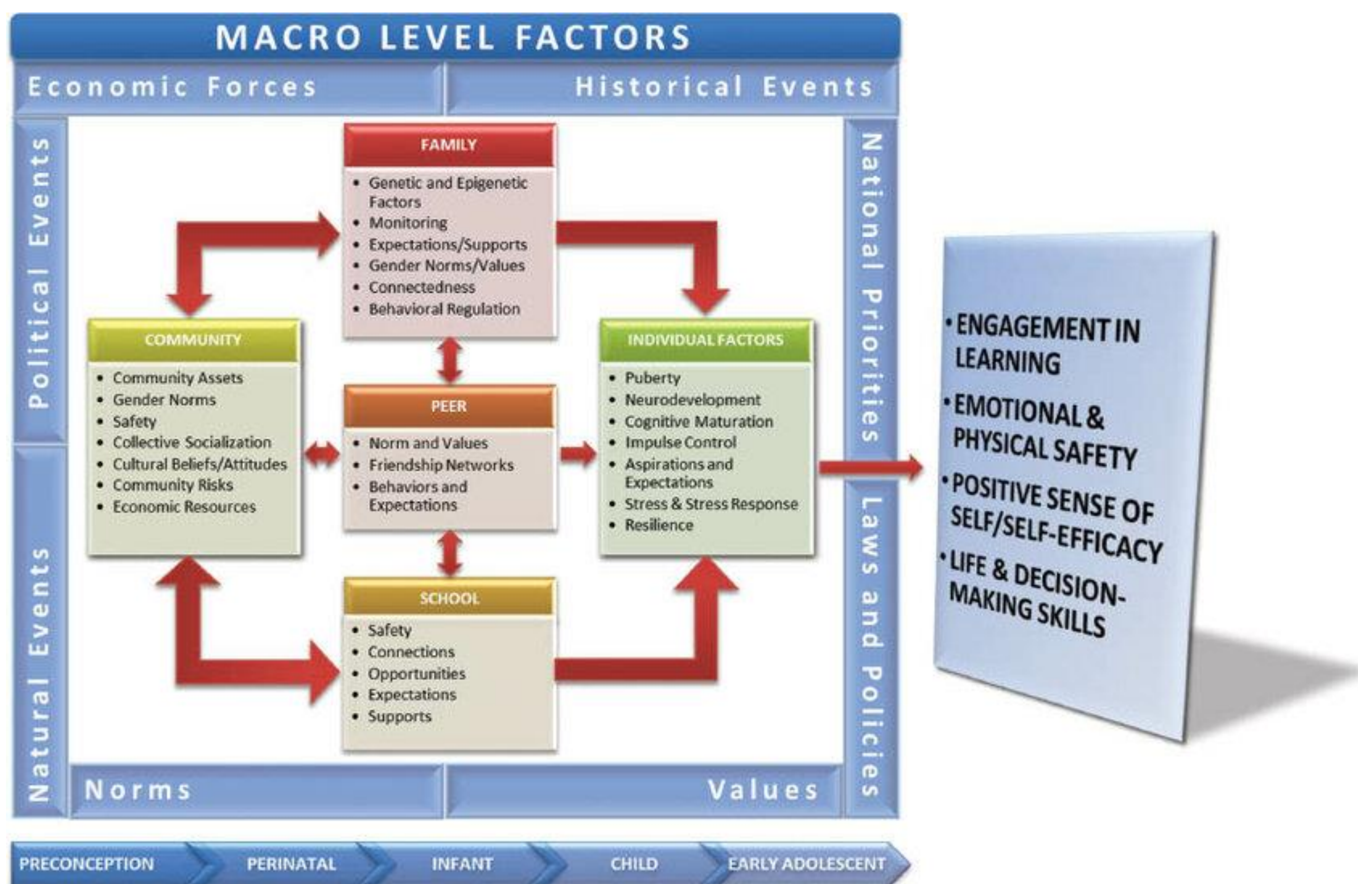
The growing interest in VYAs has led to an expansion of research, programming, and evidence related to health and gender programming with and for VYAs. A 2010 landscape review of VYA reproductive health and gender programs conducted by the Institute for Reproductive Health at Georgetown University (15) identified just 18 programs globally, whereas a 2020 landscape review conducted by Save the Children using a similar methodology identified 60 programs and five multi-country research studies. (11) Two of these research studies, Global Early Adolescent Study and Gender and Adolescence: Global Evidence (GAGE) include longitudinal data collection across multiple sites aiming to understand how gender socialization in early adolescence occurs around the world, how it shapes health and wellness for individuals and their communities, and what works to enhance adolescent capabilities and empowerment.

SBC programming addressing VYAs, families, communities, and systems may contribute to reducing adolescent childbearing.

SBC programs that engage VYAs, their families, their communities, and the systems that impact VYA lives are important to addressing adolescent childbearing for two related, yet distinct, reasons. First, these programs may contribute to delaying childbearing during the VYA stage of life (i.e., pregnancy between the ages of 10–14). Data on this age group is extremely limited, so there is not currently direct evidence of the potential of SBC in this regard; however, there is evidence that SBC can contribute to contraceptive uptake and reductions in adolescent childbearing among 15–19-year-olds. (16,17) As such, it is plausible to assume that SBC programs adapted and tailored to the younger VYA age group could have similar outcomes. Second, SBC programs can aim to intervene with VYAs, their families, their communities, and the systems that shape their choices to promote knowledge, attitudes, skills, behaviors, and norms that will enable the delay of childbearing at later stages of adolescence (e.g., after the VYA stage of life). This pathway of

change is aligned with the 2014 conceptual framework put forward by Blum et al. (see Figure 1), which describes the multiple factors and levels that influence the healthy development of VYAs.(18) The framework identifies four central goals for adolescents to reach at the completion of early adolescence—engagement in learning, emotional and physical safety, positive sense of self, and life and decision-making skills. Blum et al. suggest that when these "building blocks of healthy development" are in place, they are associated with key sexual and reproductive health outcomes, including later onset of sexual debut and improved contraceptive utilization. SBC programs have been shown to be effective in improving several of the goals put forward by Blum et al., and VYA SBC programs have been effective at fostering gender equitable attitudes, behaviors, and norms and improving reproductive health knowledge and behaviors. (19–22) Although longitudinal data connecting these intermediate outcomes to later outcomes related to marriage or childbearing are not yet available, it is a reasonable expectation that these intermediate outcomes may lay a foundation among adolescents for later ability to use contraception and choose if and when to get pregnant. Both GEAS and GAGE, mentioned above, are hoping to understand this pathway better.

Figure 1: A conceptual framework for healthy adolescence



There is emerging evidence pointing to the key features for effective VYA SBC programming, but evidence gaps remain.

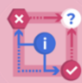
There is growing evidence that suggests that key features of SBC programming effectively improve intermediate gender and reproductive health indicators among VYAs. These are listed below and summarized in Save the Children's Very Young Adolescent Sexual and Reproductive Health and Gender Program Design Guide. However, as noted above, evidence is still lacking on whether these early investments translate into delayed childbearing as adolescents grow up.

- **Implement tailored interventions at multiple levels of the socio-ecological model (SEM):** VYAs are rarely, if ever, the primary decision-makers for their lives. Their parents; in-laws; community leaders; and health, education, and social protection systems influence their development and decisions about marriage and childbearing. Interventions must meaningfully engage these different levels to shift attitudes, behaviors, and norms related to gender, child marriage, and adolescent childbearing. (6,7,9,23–25)
- **Address inequitable social and gender norms**: Incorporating norms-shifting approaches into SBC programming is critical to change the inequitable gender norms that ultimately drive child marriage and adolescent childbearing across a range of contexts. Addressing these norms requires the use of evidence-based norms-shifting techniques that prioritize reflection, dialogue, and critical thinking, as described in this brief on attributes of community-based norms-shifting interventions, and aligning intervention design with global guidance on gender-transformative programming. (1,6,7,15,23,26)
- **Engage boys and girls using gender-synchronized strategies**: Historically, VYA girls have been prioritized in health and gender programming, but evidence suggests that engaging boys is critical. Boys are also negatively impacted by gender inequality and poor reproductive health outcomes, and their engagement is critical to making changes in the patterns and practices related to child marriage and childbearing as they age. (27)
- **Respond to the heterogeneity of VYAs**: VYAs are extremely diverse and are different than older adolescents. Programs must intentionally tailor content to the unique VYA life stage and brain development. Effective engagement approaches include breaking down complex concepts and using clear, simple language to relay information and ideas; relating ideas, such as gender norms, to their lived experiences (e.g., related to chores in the household or teasing); featuring inspiring role models who can help VYAs develop healthy goals and aspirations; and using a variety of short, interactive and fun games catering to VYA's short attention span. (12) At the same time, programs must make adjustments to meet the unique needs of VYAs who are most impacted by inequality and discrimination, including VYAs with disabilities, ethnic minorities, and those who are displaced and/or living in conflict. (1,26)

Two case studies of SBC programs that intentionally targeted VYAs and embody these evidence-based practices are included at the end of this section. These programs aimed to improve gender equitable attitudes, behaviors, and norms among VYAs and their families, communities, and institutions, and improve reproductive health knowledge to lay the foundation for delaying further the harmful practices of child marriage and childbearing.

There is a robust body of evidence on child marriage prevention, but it does not specifically address VYAs.

This review focused on SBC programs that engage VYAs and aim to contribute to reductions in adolescent childbearing or the drivers of adolescent childbearing. With this in mind, Agency for All has grounded this work in the global VYA health and gender programming landscape and evidence described above. However, it is worth noting that there is a related, but somewhat distinct, body of evidence on strategies to prevent child marriage, which is a driver of adolescent childbearing in some contexts (including Bangladesh). Some child marriage programs engage VYAs, but some do not. With the exception of work by Erulkar and Muthengi in Ethiopia, the child marriage prevention literature does not distinguish between approaches for younger adolescents who are at risk for marriage and older adolescents. (28) The Girls Not Brides theory of change offers a synthesis of current evidence and thinking on child marriage prevention. It puts forward four key strategies that are necessary to catalyze change: 1) advancing girls' leadership and rights; 2) mobilizing families and communities; 3) providing services; and 4) establishing and implementing laws and policies. A 2012 review of 23 evaluated child marriage programs reinforces the Girls Not Brides theory of change. (29) However, a 2020 review of 20 years of child marriage programming found that interventions that support girls' schooling through cash or in-kind transfers show the clearest pattern of success in preventing child marriage and calls into question the effectiveness of multi-component SBC programs that focus largely on empowering adolescent girls through small group and curricula-based approaches. (30) Others have suggested that these conclusions are premature and that some of the findings are attributable to challenges with both implementing and evaluating multi-component SBC programs (rather than inherent ineffectiveness). (31) The WHO is currently updating its Global Guidelines on Preventing Child Marriage and Adolescent Childbearing and aims to grapple with these questions regarding intervention effectiveness. Still, however, the divergent experiences of VYAs and older adolescents remain unaddressed for the most part.



CASE STUDY

CHOICES, VOICES, PROMISES

Location: Nepal, with adaptations in 10 additional countries including Bangladesh
Ages reached: 10–14

Choices, Voices, Promises is a gender-transformative social and behavior change approach that aims to improve gender equitable attitudes, behaviors, and norms related to child marriage, education, and sexual and reproductive health among very young adolescent girls and boys aged 10–14, their families, and their communities.

Choices is a participatory, curriculum-based intervention that engages VYA boys and girls in facilitated games and activities, reflection, and dialogue. Choices is implemented through 9–12 small group sessions led by a trained facilitator, who is either an older adolescent or a young adult. Groups meet weekly or every other week in safe places, including schools and community centers. In many contexts, the boys and girls are mixed in groups, but in some contexts, girls and boys meet separately with same-sex facilitators. The Choices sessions explore the following themes: gender inequity and power, including the recognition that gender equity begins with small actions that earn respect from others; social norms that restrict boys and girls from having equal opportunities and treatment; how boys and girls can express emotion and realize their hopes and dreams; gender equitable roles of boys and girls in the household and education; bullying and teasing; puberty; and gaining support from others to continue education and delay marriage.

Voices engages the parents and caregivers of VYAs in six group-based discussion, reflection, and action planning sessions focusing on the same topics covered in the Choices sessions. Caregivers from the communities who demonstrate more gender equitable practices in their homes and are committed to delaying marriage record videos or audio testimonials that are used to catalyze the facilitated group discussions with parents. Caregiver

discussions are held in convenient community locations and are facilitated by a trained adult facilitator (often from a local organization or government community worker cadre). Sessions are typically mixed sex, but in some settings, female caregivers meet separately from male caregivers to ensure full participation.

Promises is a unique facilitated community dialogue and action planning approach that aims to engage key influencers and decision-makers in reflection and action on gender equity the lives of VYAs and their families, VYA health, and child marriage. Different posters, which use pictures and text developed by local artists to cover the same themes as Choices and Voices, are posted at a central location in the community for at least one week. A facilitated discussion with community leaders is then held to reflect on each theme addressed on the posters and commit to action. There are typically six to seven Promises posters and sessions. They are facilitated by a trained adult facilitator from a local partner or government cadre. Groups are typically mixed sex and include religious and civic leaders, teachers, social workers, health care workers, and other influencers specific to the context.

Evaluation and Results

Choices, Voices, Promises was developed by Save the Children in Nepal in 2009. Choices, and then, later, Choices, Voices, Promises, was rigorously evaluated in Nepal by the Institute for Reproductive Health at Georgetown University through a mixed method, quasi-experimental evaluation using baseline and endline surveys and participatory qualitative methods with VYAs and their parents.

Results in Nepal demonstrated improvements in gender equitable attitudes and behaviors among VYAs and their parents. For example, VYAs exposed to program interventions had three times higher odds of disagreeing with norms that boys who help with chores are considered weak by their friends, and had two times higher odds of talking about their hopes and dreams with their family. Parents exposed to Choices, Voices, Promises were more likely to believe that marrying girls at an early age is harmful to the community, and VYAs were more likely to have told their parents that they want to continue studying.

Adaptation to Bangladesh

Choices, Voices, Promises has been adapted and implemented in more than 10 countries, including Bangladesh. In Bangladesh, USAID's MOMENTUM and Global Leadership project provided technical and organizational capacity development to two local organizations to implement and document the approach. The process and learning from this work have been captured here. In addition, Save the Children has used private resources to implement Choices in Bangladesh for several years, and recently added the implementation of Voices and Promises. Save the Children is currently implementing and evaluating Choices, Voices, Promises in the Muladi and Bakerganj sub-districts of the Barishal division.

Key Learnings

- Concepts of gender norms must be made more concrete for VYAs by relating gender to their day-to-day experiences, such as through household chores, school, and peer dynamics, and through the use of pictures, toys, and games specifically tailored to their age. Linking reflection and dialogue among VYAs with commitments for practical, age-appropriate actions they can take, such as sharing chores at home or stopping teasing, is important to move from attitudinal change to behavior change.

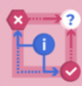
- Using videos and posters with parents and community members helped catalyze deeper reflection on key norms in the community compared to more traditional community dialogues that relied on more didactic speaking methods. Complementing that deeper reflection with opportunities for parents and community members to make public commitments to action enabled greater ownership and change among these influential groups.

- The implementation of the parent and community components alongside Choices was essential and in line with both evidence and the SEM. Implementers found the synchronization of the themes and topics to be of paramount importance so that the VYA intervention was reinforced through the parent and community components.

- Choices, Voices, Promises is relatively "light touch," with only 9–12 sessions for VYAs and fewer for parents and communities. It can be implemented and scaled through community-based partners or structures as well as schools. However, ongoing capacity development of the small group facilitators and supervisors on how to address gendered attitudes, behaviors, and norms with VYAs, as well as with their parents and community members, was critical for quality implementation and would have to be part and parcel of any scale-up strategy.

Lundgren R, Beckman, M, Chaurasiya, SP, Subhedi, B, & Kerner, B. Whose turn to do the dishes? Transforming gender attitudes and behaviours among very young adolescents in Nepal. Gender & Development. 2013 Mar; 21(1):127-45.

Lundgren R, Gibbs S, Kerner B. Does it take a village? Fostering gender equity among early adolescents in Nepal. International Journal of Adolescent Medicine and Health. 2018 Apr 30;0(0).



CASE STUDY

GENDER EQUITY MOVEMENT IN SCHOOLS (GEMS) PROGRAM

Location: India with expansion to Bangladesh, the Philippines, and Vietnam
Ages reached: 12–14

The Gender Equity Movement in Schools (GEMS) program is a school-based intervention aimed at fostering gender equitable attitudes, examining social norms that define the roles of men and women, and countering gender-based violence among young adolescents. In partnership with the Committee of Resource Organizations for Literacy (CORO) and the Tata Institute of Social Sciences (TISS), the International Center for Research on Women (ICRW) developed and implemented a curriculum to engage young girls and boys to discuss and critically reflect on issues related to inequitable gender norms and violence. Focusing on 12- to 14-year-olds, GEMS begins when students enter the sixth grade.

GEMS uses a gender relational and gender transformative approach that focuses on engaging girls and boys from a young age, while also working to transform institutions. The GEMS curriculum includes classroom sessions on gender, violence, and bodily changes, and relationships, emotions, communication, and conflict resolution delivered over two academic years. GEMS blends teacher-led group education in the classroom, including games and role-playing, with school campaigns and extracurricular activities.

GEMS was implemented in public schools in India in five states—Goa, Maharashtra, Bihar, Rajasthan, and Jharkhand—using different approaches. For example, in Rajasthan, the program was layered with ongoing school curriculum, while in Mumbai (Maharashtra), it was implemented as an independent project in 45 schools (then later scaled across ~20,000 schools in the state). The evaluation of the pilot in Mumbai demonstrated the potential of

GEMS to engage young adolescents on issues of gender and violence. Additionally, it found that the intervention resulted in positive and significant shifts in attitudes around gender and violence, improved communication between students, enhanced recognition of violence, and reduced the acceptance of violence among peers. Since the pilot program in 2008, GEMS has reached 2.5 million students in 25,000 schools, and 26,000 teachers have been trained in the successful implementation of the program across Maharashtra, Rajasthan, and Jharkhand in India. The program has also expanded to Bangladesh, the Philippines, and Vietnam.

Adaptation to Bangladesh

In 2013, the Generation Breakthrough (GB) program was launched through a partnership between the United Nations Population Fund (UNFPA), the GoB, Plan International, and other community-based organizations. The GB program included the GEMS curriculum and was implemented in 350 schools and madrasas and the communities surrounding the schools across four districts: Dhaka, Barishal, Patuakhali, and Barguna. The government assumed the responsibility of implementing the GB program, which included GEMS, in schools. Their approach involved training approximately 1,400 teachers, with two to five teachers selected from each school, to deliver the program within regular school hours as extracurricular activities. Additionally, students were provided with an activity book, called "the GEMS diary," which served to reinforce the messages conveyed in the classroom. The diary also aimed to involve parents and siblings in discussions related to gender and violence.

Evaluation and Results from Bangladesh

A three-arm quasi-experimental design was used to evaluate the GB program's effectiveness. The first arm consisted of schools that implemented the comprehensive GB program. The second arm, known as the "GEMS arm," consisted of schools that only implemented the GEMS intervention. The third arm, termed as the "Non-GEMS," or control, arm, included schools that did not implement the GB program. A comparison between the GEMS arm and the Non-GEMS arm presents interesting findings.

During the first year of GEMS implementation, there were significant positive shifts in specific statements related to gender attributes, violence, and division of work. There was an increase in the proportion of students who disagreed or strongly disagreed with the beliefs that boys are inherently violent and girls are naturally tolerant. This indicates a positive change in students' perceptions with regards to challenging gender stereotypes. Students exposed to the GEMS program transitioned from silence to openly discussing incidents of violence. They demonstrated a shift towards non-violent responses, although they struggled with internal conflicts in restraining themselves from violence. Linear regressions of the data also pointed to a dose effect. Participants who attended nine sessions or more showed a "gender attitudes" mean score that was 2.8 points higher than those who attended eight sessions or less.

Key Learnings

- GEMS highlights the potential of schools to function as an institution to transform gender norms, moving beyond a focus on traditional teaching-learning objectives. The program demonstrates how teachers, mentors, and coaches can play an important role in an ecosystem's approach in sustaining changes through inclusive pedagogy and supportive institutional practices.

- The GEMS program prioritized engaging teachers and enlisting them as allies in leading the program. Therefore, investment in building transformative training skills among teachers and change agents is critical to success, and factors such as the type of training, duration of intervention, delivery method of program content, and external support provided to teachers all play a role in the success of the program in different contexts. For instance, in Bangladesh, the large number of teachers who required training necessitated a cascade approach for training, which is often linked with dilution of program impact.

- In creating the program, it was critical to develop a comprehensive conceptual guiding framework and to include localized and contextually relevant gender content.

- GEMS benefited from the use of a combination of quantitative and qualitative measurement tools to assess change. The evaluation highlighted the ongoing lack of trust among students in the ability of adults to respond to violence. This emphasizes the importance of holistic programs that go beyond the school setting to impact every aspect of a child's ecosystem. Challenging harmful norms requires a multifaceted approach involving different stakeholders and encompassing the broader social context in which children live.

CHANGING COURSE Implementation and Evaluation of the Gender Equity Movement in Schools (GEMS) program in specific sites -Vietnam, India and Bangladesh [Internet]. 2017. Available from: https://www.icrw.org/wp-content/uploads/2018/10/GEMS-Evaluation-Report-18-06-2018-UPDATED.pdf

The Context and Drivers of Adolescent Childbearing in Bangladesh

Adolescent Fertility and Childbearing

Bangladesh has made significant progress against multiple health, social, and economic indicators. Notably, the total fertility rate has rapidly declined from 5.5 in 1985 to 2.3 in 2022. (3) Although the GoB recommends delaying childbearing to the age of 20, adolescent fertility in Bangladesh remains the highest among all South Asian countries. (32) Adolescent childbearing, especially for girls under the age of 15, can have serious health implications for both adolescent mothers and their babies. (2) According to a 2016 survey on Bangladesh maternal mortality and health care, 144/100,000 adolescents aged 15–19 died of maternal-related causes, compared to an overall maternal mortality ratio of 196/100,000 births for all women aged 15–49. (33) Promisingly, BDHS data shows adolescent fertility is steadily declining. Age-specific fertility rates for adolescents in 2017–18 were reported at 108 per 1,000 adolescents aged 15–19 and (estimated) five per 1,000 adolescents aged 10–14. In 2022, those rates declined to 92 per 1,000 adolescents aged 15–19 and (estimated) two per 1,000 girls aged 10–14. (34)

Drivers of Adolescent Childbearing

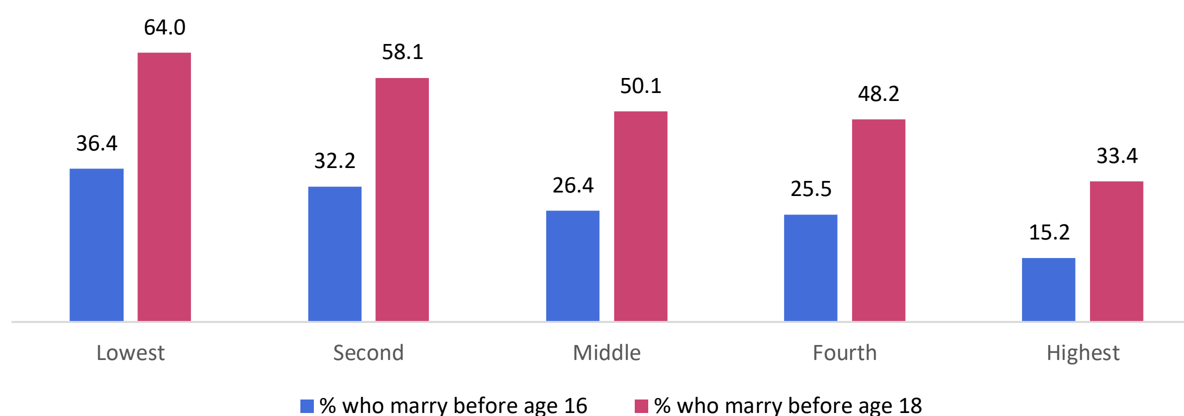
The two most significant drivers of adolescent childbearing are child marriage and rapid childbirth soon after marriage. Premarital sexual activity is also a driver not only of pregnancy, but of child marriage as well. These three drivers in turn each have their own sets of unique drivers. In addition, there are new and emerging drivers that are less understood, such as the impacts of climate change, health crises like the COVID-19 pandemic, and humanitarian crises. This collection of drivers is briefly described in this section.

CHILD MARRIAGE

There is consensus both in the literature and among respondents in this review that most adolescent pregnancy and childbearing in Bangladesh takes place in the context of marriage. (35) The GoB has actively worked to end this practice. In 2017, it instituted the Child Marriage and Restraint Act (CRMA), which forbids marriage for girls before the age of 18, although it allows for exception when parental permission is given. The percentage of girls married under age 16 has steadily declined from 43 percent in 2011 to 27 percent in 2022, (3,34) an indication that the age of marriage is slowly increasing. Nonetheless, Bangladesh still has the highest rate of child marriage in South Asia with 50.1 percent of Bangladeshi women married by age 18 and 26.7 percent married by age 16. (36) The key drivers of child marriage in Bangladesh are **poverty, lack of education and economic pathways, and social and gender norms.**

Poverty: The 2022 BDHS shows that poverty has a strong relationship with child marriage, as shown in Figure 2, and nearly all participants in this research review agreed. In the absence of clear pathways to tertiary education or quality employment opportunities, many families see marriage as the only viable alternative to secure the financial futures of girls. The literature points to the economic benefits that child marriage can confer, especially among the poorest Bangladeshis, by, for example, shifting the burden of support to the husband's family, or reducing the amount of dowry a family is expected to pay. Younger, less educated girls are seen as more desirable for marriage, as families may be able to pay a smaller or even no dowry, compared with older girls, who may be perceived as more “difficult” or less easy to “control.”

Figure 2: Wealth quintile and age of marriage



Source: BDHS 2022

Lack of education and economic pathways: Primary school enrollment for girls in Bangladesh is almost universal, and nearly half of all girls attend some secondary school. However, secondary school dropout, which remains higher for girls than boys (a disparity that continues to increase at the tertiary level), is intimately tied to child marriage. The association between secondary school completion and reduced rates of child marriage is clear: girls who marry after age 18 have remarkably high levels of secondary school completion. (36)

Girls drop out of school for many reasons, including child marriage, pregnancy, household responsibilities, mental health concerns, school-based violence, and perceptions among family members that educating girls is still not as high of a priority as educating boys. Some parents may see little value in their daughters completing secondary education, as there is a lack of clear pathways to tertiary education or quality employment opportunities, and many see marriage as the only viable alternative to secure the financial futures of girls. Despite laws against child labor, the International Labor Organization (ILO) reports that 4.7 million, or 13.4 percent, of Bangladeshi children aged 5–14 are working, and of that number, around 1.3 million are girls. A significant number are employed in the garment industry, which is widely seen as unsafe and exploitative. (37) Given these realities, families may find marriage to be a more viable or a safer option than continued schooling for uncertain future gain or early entry into potentially dangerous industries.

Social and gender norms: In both the global and Bangladesh-specific literature, social and gender norms are well established as a key driver of child marriage. Parents (especially fathers) are seen as holding absolute authority, to which adolescents—especially girls—should submit, including decisions about if and when a girl will marry. Even in instances when parents may not agree with prevailing norms and wish to wait to marry their daughter, communities may exert pressure to comply, and parents may fear negative community sanctions in the form of gossip, stigma, and loss of social status. (38) Parents may also see child marriage as a beneficial protective factor against risks arising from gender normative expectations and behaviors, such as harassment, sexual violence, or the threat of being labelled as a "bad" girl. There are also strong gendered norms that lead to taboos around "illicit" relationships or the occurrence of pregnancy outside of marriage, which can lead to pressure to marry girls early to prevent such occurrences.

RAPID CHILDBIRTH SOON AFTER MARRIAGE

Marriage almost invariably leads to sexual initiation. This pattern of marriage being followed quickly by childbearing is confirmed by data that shows the median age of marriage is 17.3 and the median age of first

pregnancy is 19.5 among 20–24 year-olds in Bangladesh. (34) Pregnancy soon after marriage is primarily driven by two factors: social and gender norms and a lack of access to contraception.

Social and gender norms: The pattern of childbearing soon after marriage is closely tied to social norms. Multiple respondents from interviews and consultations acknowledged that prevailing social and gender norms lead to an expectation among families and community members of pregnancy in the first year of marriage. Indeed, a 2020 paper reports, "married adolescent girls often have children soon after marriage to prove their fertility, please their in-laws, and establish their position in the family and community. Fear of stigma around infidelity, a lack of access to, and appropriate knowledge of, contraceptive methods and severe limitations in mobility and decision-making power further decrease girls' ability to prevent childbirth soon after marriage." (39) There are also immediate social benefits for adolescent girls who adhere to this social norm of becoming pregnant in the first year of marriage in terms of improved social status, increased agency over her own decisions and actions, and reduced social isolation. In contrast, there are fewer immediate social benefits to delaying first pregnancy, as well as few alternative pathways for education or livelihoods for married adolescent girls.

Access to and use of contraception: The GoB has supported access to high quality contraceptive services for married women of reproductive age, and the use of modern contraception has steadily increased from 13.6 percent among currently married women aged 15–49 in 1975 to 55 percent in 2022. (3) Most recently, the GoB made a commitment to FP2030, which is inclusive of adolescents. However, the commitment does not discuss contraceptive services for adolescents of any age, even though modern contraceptive use is lowest and the unmet need is highest among married adolescent girls aged 15–19 compared with all married women of reproductive age. Among married adolescents aged 15–19, 48 percent are using a modern method of contraception, compared with 55 percent of all married women. (3) This figure is even lower for nulliparous women, with only 22 percent using a modern method of contraception. (3) The unmet need for FP for married adolescents is 12.7 percent compared with 10 percent for all married women of reproductive age. (3) Adolescents mostly use short-acting contraceptive methods (i.e., pills [27.8 percent], condoms [11.3 percent], and injectables [7.5 percent]), due in part to the common policy interpretation that nulliparous women cannot use long-acting reversible contraceptives. Contraceptive discontinuation rates are high among adolescents, with 37 percent of married adolescents aged 15–19 discontinuing contraceptive use after one year, mostly due to contraceptive side effects, their husbands' absence due to work or migration, or a desire to become pregnant. (34)

There are also systemic barriers that limit married adolescents', including married VYAs', access to and sustained use of contraception. For example, although community health workers (CHWs) are an important source of contraceptive information and methods for many married women given the distance for many to health facilities, married adolescents have less contact with CHWs and are less likely to be provided with a method. In addition, adolescents, who are more likely than adults to experience judgment or disrespectful treatment from health care providers, experience challenges in accessing services discretely, and may be asked to obtain spousal or parent/in-law consent to receive contraception. (40)

It should be noted that education is a protective factor that contributes to fertility declines and increased contraceptive use. Adolescent girls with no education have 2.76 times higher odds of becoming mothers than their counterparts with more than a secondary education, and a 2023 analysis of data from the 2018 BDHS reported a robust negative association between fertility and educational attainment. (41)

PRE-MARITAL SEXUAL ACTIVITIY

Pre-marital sex, while highly taboo, is a driver of not only pregnancy, but child marriage. According to a 2022 paper that reported data from the 2014 Bangladesh Global School-based Health Survey, there is a paucity of available information about "whether and in what context sexual debut among adolescent boys or girls may occur prior to marriage." The survey findings showed 9.4 percent of students aged 13–17 have had sexual intercourse, with boys being much more likely to report having had sex than girls. (42)
A 2023 analysis of the 2017–18 BDHS data reported evidence that three out of every four ever-married women aged 15–24 were married before the age of 18, and one-third of them had had sexual intercourse prior to their marriage. (43) The paper further reports that ever-married women in both rural and urban settings who experienced child marriage had higher odds of reporting premarital sexual experience, which suggests marriage may "cover up" instances of premarital sex and/or pregnancy.

Unmarried adolescents' access to and use of contraception is highly taboo. The Population Reference Bureau (PRB) reports that Bangladesh's National Strategy for Adolescent Health cites a regulation that SRH services can only be made available to married women and eligible couples, although the PBR was not able to verify the existence of this regulation. (44) Bangladesh's Costed Implementation Plan for the National Family Planning Program alludes to the same regulation and describes strategies to reach newlyweds with contraceptive information, counseling, and contraceptive methods, but there is no specific mention of the contraceptive needs of adolescents.

NEW AND EMERGING DRIVERS

In addition to these well documented drivers of adolescent childbearing and child marriage summarized above, there are new and emerging drivers that are less understood, such as the impacts of climate change, health crises like the COVID-19 pandemic, conflicts, and humanitarian crises. These new challenges are creating instability, uncertainty, and new pressures which can further drive child marriage and associated adolescent pregnancy. Some of these emerging challenges are further explored under Insight 7 of this report.

Government Plans and Strategies to Address Adolescent Childbearing and Child Marriage

Two key GoB strategies to prevent child marriage and adolescent childbearing are the 2017 Child Marriage Restraint Act (CRMA) and a government recommendation to delay childbearing to age 20. The literature review suggests a high level of awareness of the CRMA, but many key informants and community consultation participants felt that awareness is still insufficient and recommended continued activity to increase awareness of the law and consequences of child marriage, such as early childbearing. Respondents also suggested that awareness creation activities need to be better targeted to those who hold power over decision-making in families, particularly mothers-in-law and parents, as well as community members who wield influence, such as law enforcement, religious leaders, local government representatives, and teachers. It is important to note, however, that research respondents noted much less awareness of the government recommendation to delay first pregnancy to age 20.

The GoB has developed multiple policies that are intended to support the implementation of the CRMA and to delay childbearing. Agency for All reviewed four policy documents deemed most pertinent to this review, which are summarized below:

- The **National Adolescent Strategy (NAS)** is a high-level strategy to guide GoB investments in adolescents across five domains: health, learning, safety, transition to work, and participation. It is inclusive of both VYAs (aged 10–14) and older adolescents (aged 15–19) and lists 20 policies and plans that address different aspects of adolescents' lives, noting that widespread policy coverage is hampered by a lack of implementation and poor coordination. Strategies in the NAS address many of concerns identified in the literature review and by key informants, such as support for parents of adolescents, the social insecurity of girls, and the need for increased vocational skills training opportunities. It proposes a systems approach, better coordination, and collaboration across sectors and with communities, along with the formation of a high-level interagency working group and a technical working group to facilitate and monitor its implementation.

- The **National Strategy for Adolescent Health (NSAH),** drafted by the Maternal and Child Health (MCH) Services Unit and the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MoHFW), identifies four health priorities—sexual and reproductive health, violence, mental health, and nutrition—as well as social and behavior change and health systems strengthening as cross-cutting areas of focus. The strategy discusses the need for programs that provide quality, age-appropriate SRH information and services to adolescents, "beginning with the very young adolescents (10-14 years) and continuing until they become adults." The strategy acknowledges the need to reduce child marriage and early childbearing and recommends creating an enabling environment, providing information, supporting skills development, and promoting positive social norms.

- The **National Action Plan to End Child Marriage** was launched in 2018, with support from Bangladesh's Prime Minister. The plan discusses the main drivers and consequences of child marriage, spotlighting VYAs' risk of childbearing and cites ongoing policy efforts to reduce child marriage, including free education, marriage registration, and the prohibition of dowries. It also defines children to include those up to age 18, making adolescents eligible for child protection. The plan aims to eliminate child marriage by 2041 through ongoing responsive activities that hold the government accountable, promote positive social norms, empower all adolescents, provide a social safety net, and ensure girls' access to education and employment. The Ministry of Women and Children Affairs (MoWCA) is the lead ministry charged with coordinating a national child marriage prevention committee to oversee the plan's implementation at all levels of government.

- The **Comprehensive Social Behavior Change Communication Strategy** of the MoHFW was developed to support the implementation of the 2016–21 Health Sector Plan by promoting healthy behaviors, positive social norms, and the use of available services. It advances a coordinated, audience-centered approach to health that is multi-level, multi-channel, and makes uses of multiple communications technologies. It discusses adolescent health in some detail, and specifically recommends SRH education for unmarried adolescents. The strategy also provides comprehensive guidance on how to implement effective social and behavior change communication (SBCC) programs, including for adolescents.

Overall, the policy environment for adolescents and VYAs appears supportive and many of the strategies and activities align with best practices. VYAs are acknowledged in several policies, as are adolescent childbearing and child marriage, along with the need for better access to SRH information and services for both unmarried and married adolescents. Respondents and informants appreciate that Bangladesh has good policies in place, but feel they are not well implemented or enforced and that there is a need for more specific policy guidance that articulates strategies and activities that will enable adolescents to delay childbearing to the age of 20.

Policies appear to be reluctant, however, to directly state that programs are needed that help married adolescents delay their first pregnancy through improved access to and use of contraception. There is little discussion of or guidance on **how** to delay childbearing, beyond a mention of the need to "(b)uild capacity for the delivery of age and gender sensitive sexual and reproductive health services." (45) Contraception or family planning are barely mentioned, except for noting lower contraceptive use among adolescents and higher levels of unmet need for contraception. VYA needs are primarily described in terms of their vulnerability to HIV, poor mental health, and noncommunicable diseases.

There also appears to be a need to support ministries to prioritize and implement activities, especially to clarify current interpretations of policies and laws as pertaining to adolescents (e.g., whether SRH services can be provided to unmarried adolescents, or whether married adolescents can use long-acting reversible contraceptives). Several policies mentioned the establishment of committees, networks, and coalitions, which can contribute to more collective and complementary policy implementation of policies, although it is unclear if these mechanisms are operational or effective. Enhanced support may enable ministries and sectors to work together more effectively, reducing what appears to be a piecemeal and at times weak implementation at the district level of programs and policies designed at the national and division levels. Billah et al. observes that efforts to improve adolescent outcomes may lag where there are particularly weak local administrative bodies. (46)

Key Insights

The findings have been synthesized across all the data collection activities to arrive at nine key insights about the status of VYA SBC programming that may contribute to preventing adolescent childbearing in Bangladesh. These insights were shared with and validated by the CCG and with stakeholders in the Solutions Workshops. The following sections present each insight, with supporting details and findings from the literature review, key informant interviews, mapping, community consultations, and Solutions Workshops.

9 KEY INSIGHTS

1. Very few interventions tailor strategies to reach VYAs, especially those aged 10–12.
2. While some interventions directly address delaying pregnancy, more focus on health education or child marriage.
3. Most SBC interventions fall into one of four intervention types but show limited impact on key outcomes, and data needed to consider scale-up is slim.
4. SBC programs face constraints in effectively working across levels of the SEM to address determinants.
5. Strategies that address social norms and related determinants of adolescent childbearing are largely absent in current VYA SBC activities.
6. SBC programs addressing adolescent childbearing and child marriage are not consistently intervening where the need is greatest.
7. SBC programs addressing adolescent childbearing and child marriage are not evolving to meet changing conditions.
8. A lack of data, learning, and evidence on VYA SBC programming in Bangladesh constrains development of programs and policies to address adolescent childbearing.
9. VYAs may fall through the cracks between different sectors and ministries, limiting the ability to scale and institutionalize programming.

Projects are needed with the 10-14 aged adolescents, as there are lots of risks among them for the bad effects of child marriage and childbearing…

Mapping Interview

INSIGHT 1: Very few interventions tailor strategies to reach VYAs, especially those aged 10–12.

Of the 17 adolescent interventions identified in the literature, 15 reported that some or all of their program beneficiaries were within the VYA age range. Five programs included all adolescents aged 10–19, one focused on adolescents aged 10–18, one specifically targeted VYAs 10–14, two programs did not define an age range, and six programs excluded younger VYAs aged 10–12 from their stated range (see Table 3).

Out of the 22 organizations working with adolescents that were interviewed for the mapping exercise, 17 stated they work with age ranges that touch on at least a portion of the 10–14 VYA age range. Six organizations included all adolescents aged 10–19, one specifically targeted VYAs (10–14), four did not specify an age range, while others reached children and adolescents of different age ranges starting from as young as eight to as old as 19 (see Table 4).

Table 3: SBC programs and target groups identified in the literature (by age)

Target group age range	Number of programs (n= 17)
No age range given	2
All adolescents (10-19)	5
10-14	1
10-18	1
10-19	1
12-16	3
12-17	1
12-18	1
13-18	1
14-18	1

Table 4: SBC programs and target groups of the mapping interviewed organizations (by age)

Target group age range	Number of organizations interviewed (n= 22)
No age range given	4
All adolescents (10-19)	6
8-15	2
9-14	1
10-14	1
10-17	1
10-18	3
11-18	1
12-18	1
13-19	1
15-19	1

On the whole, these results suggest that there are a number of interventions and organizations in Bangladesh that include subsets of ages within the VYA category. However, VYAs are typically addressed as part of a larger bracket of ages, and very few interventions specifically and intentionally target VYAs as a specific group. Global evidence, including recent research on adolescent brain development, shows that the information needs and learning capabilities of adolescents are continually evolving and that content must speak to the heterogeneity of adolescents. UNESCO's 2018 International Technical Guidance on Sexuality Education, for example, highlights the importance of tailoring content to specific, smaller, age-based subgroups within the adolescent age range. (47) This underscores the need for SBC programs that are tailored to the unique life stage and brain development of VYAs. Despite this, the program documents reviewed for this report did not, for the most part, articulate such specific strategies or activities to engage with VYAs. Interviews conducted as part of this research further indicate that in most cases, programs are implemented for all adolescents collectively with little to no effort to develop age-appropriate content.

FACTORS LIMITING PROGRAMMATIC CONSIDERATION OF VYAs

The research conducted for this review suggests two important factors that limit greater consideration of VYAs in programming: 1) VYA-specific programming is not seen as needed or a priority for implementers or donors; and 2) there are perceived significant challenges in reaching VYAs.

Respondents pointed to many reasons why SRH programming for VYAs may not be seen as a priority. First, there is a perception of limited SRH needs among VYAs, and thus low demand for SRH programming. Instead, issues such as safety, child protection, security, hygiene, menstruation support, or treatment for anaemia are viewed by program planners as more salient to this age group. Second, some respondents feel that VYAs are not the right demographic on which programs should focus, as VYAs are too young to make their own decisions. Instead, they suggest that programs should focus on the parents of VYAs. One respondent suggested that programs should be targeting older adolescents since the median age of marriage is 17.3 years old (among young women aged 20–24), which is outside of the VYA life stage. (34) There is also a perception that VYAs are sufficiently served by existing programs. While respondents acknowledge that SBC programs for adolescents are not implementing targeted activities for VYAs, VYAs are nevertheless exposed to program content, which some respondents feel is sufficient.

This lack of attention to VYAs is particularly acute for younger VYAs (e.g., aged 10–12), who, respondents report, are not a priority among donors that fund SRH programs for adolescents, especially since VYAs are not perceived to be at risk of or vulnerable to SRH risks or problems. This limited interest and lack of funding likely limits the ability of SBC interventions and programs to develop specific approaches for these VYAs.

Respondents in this research also described VYAs as very difficult to reach. Communities are quite protective of this age group, especially girls and those aged 10–12, and parents may not see value in their children participating in SBC programs. Respondents pointed to this as a significant hurdle in reaching VYAs and nearly every mapping respondent (18 out of 22) stated that conservative beliefs, superstitions, and religious practices limit the ability of SBC programs to enroll VYAs in activities.

INSIGHT 2: While some interventions directly address delaying pregnancy, more focus on health education or child marriage.

While some programs identified in this literature review and mapping explicitly aim to delay first birth, a much higher number have programmatic objectives concerned with health education, life skills, addressing gender inequities, or building agency. There are also a substantial number with objectives to delay marriage. Seventeen programs identified in the literature review work with adolescents to address one or more aspects of reproductive health (Table 5). Out of these 17, the largest number (9 programs) had stated objectives or goals related to providing adolescents with health information, helping them to develop life skills and agency, and addressing gender inequities so that they can better advocate for their own needs and aspirations. The next most frequently stated objectives related to delaying child marriage (5 programs) followed by delaying first birth (4 programs). Three programs stated objectives to *both* delay marriage *and* first birth. In all, seven programs stated an explicit goal of delaying first birth, either as standalone objective or in combination with delaying marriage.

Of the 22 local organizations interviewed as part of the mapping study, almost all (20) have a focus on delaying marriage (Table 6). This is followed by provision of health information (16), providing SRH education (11), providing safe spaces (7), promoting contraceptive use (6), and delaying first pregnancy (5).

Table 5: Programmatic objectives of programs reviewed in the literature

Programmatic objectives	Number of programs reviewed (n = 17)
Improve health knowledge, provide life skills, build agency to address gender inequities and gender-based violence (GBV)	9
Delay marriage	5
Delay first birth	4
Delay marriage and first birth	3
Facilitate community engagement/gatekeepers support for improved adolescent outcomes	3
Improve education outcomes/reduce school dropout	3
Address social norms	2
Promote healthy behaviors	2
Improve health outcomes	1
Improve menstrual hygiene management	1
Promote birth spacing	1
Provide "safe spaces"	1
Provide quality contraceptive counseling	1
Involve boys as Champions for Change	1
Prepare adolescents for labor market	1

Table 6: Programmatic goals of the organizations interviewed as part of mapping study

Relevant programmatic goals/objectives	Number of organizations interviewed (n = 22)
Delaying marriage	20
Providing health information to promote healthy behaviors/outcomes	16
Providing SRH Education	11
Providing "safe spaces"	7
Promoting the use of contraception	6
Delaying first pregnancy	5
Supporting the development of life skills and soft skills	5
Menstrual Hygiene Management	4

Overall, this data points to a heavy emphasis on health education interventions. Although such programs may not take on the issue of adolescent childbearing head on, they do have potential to contribute to the "building blocks of healthy development" Blum et al. describe in their framework (see the Global Evidence section of this report), especially when they are inclusive of content on life skills, gender roles and norms, and agency.(18) These "building blocks" are in turn associated with sexual and reproductive health

outcomes including later sexual debut and improved contraceptive use. Hence, delivering such programs with VYAs can play an important role as a long-term strategy towards reducing adolescent childbearing when they are well implemented in accordance with evidence-based best practices, such as those discussed in the Global Evidence section of this report.

It is notable that, despite GoB recommendations to delay pregnancy to age 20, a relatively small number of interventions and organizations directly address delay of pregnancy (seven out of 17 interventions described in the literature, and five out of 22 organizations interviewed in the mapping study). Respondents in this research express an overwhelming sense that taking this issue head on is not likely to be effective in the Bangladesh social and programming context. Many of those interviewed reported that the topic of delaying pregnancy is typically seen as inappropriate for unmarried adolescents, as they are viewed as children. Similarly, respondents noted that delaying pregnancy among recently married adolescents may also be seen as inappropriate, as it conflicts with the prevailing social norms that expect adolescents to demonstrate fertility in the first year of marriage. Indeed, the literature review findings support this. The programs in the literature review that explicitly focused on adolescent childbearing targeted married adolescents with one or more children (often referred to as "first-time mothers") and/or their husbands or mothers-in-law to promote the benefits of birth spacing and to support girls' access to and use of contraception for birth spacing.

The perception that discussions to delay pregnancy—whether with married or unmarried girls—may be a non-starter in Bangladesh's social normative context, led respondents to note that SBC implementers may feel it is more feasible and appropriate to focus on the prevention of child marriage, both as an objective in its own right, and as a means to delay childbearing.

INSIGHT 3: Most SBC interventions fall into one of four intervention types but show limited impact on key outcomes, and data needed to consider scale-up is slim.

The SBC programs reviewed in the literature review can be classified as falling into four intervention types: health information and education, media-based approaches, curriculum-based approaches, and multi-level approaches. Each of these is described below; however, they are not mutually exclusive, and some programs may fall into two categories. Media-based approaches and curriculum-based approaches are further broken down into approach sub-types. The sections also provide relevant examples of each from Bangladesh (for details of additional programs, see Annex 3), along with considerations that should be taken into account when planning for further use or replication of these approaches in Bangladesh.

While a healthy range of program types has been identified, many of which show promise, no programs identified in this review have been evaluated in a way to inform their readiness for scale. They lack sufficient information on costing, institutionalization considerations, or other considerations that would be needed to inform scaling.

HEALTH INFORMATION AND EDUCATION PROGRAMS

The simplest form of health education interventions are information, education, communication (IEC) campaigns that spread awareness through different communication channels to a target audience to promote a desired behavior or result. Campaigns often involve the use of small group meetings, community presentations, and the distribution of print materials (leaflets, posters, etc.).

Example in Bangladesh

- **Menstrual Management for Rohingya Adolescent Girls** was a health information program for menstruating Rohingya adolescent refugees implemented by Pathfinder International that provided basic information on menstrual hygiene management (MHM). The program distributed leaflets and facilitated small group discussions for girls aged 12–17 on how to manage menstruation and where to obtain sanitary pads. (48) (Adolescent age range targeted: 12–17)

Evidence: Often health information interventions result in increased knowledge on key health topics, but limited changes in behavior. For example, in the Menstrual Management for Rohingya Adolescent Girls program noted above, Rohingya girls who participated in the intervention reported increased knowledge and normalization of menstruation and greater willingness to use sanitary pads, although there are high levels of social embarrassment among many girls as menstruation is stigmatized.

Considerations: The global evidence and best practice is clear that while knowledge is sometimes a necessary step towards behavior change, SBC programs to address highly complex and normative issues, such as adolescent childbearing, must go beyond information dissemination and awareness creation and focus on multi-level approaches to shift norms. While knowledge is a necessary component to addressing adolescent childbearing, there is a need for emphasis on interventions that include knowledge generation as *part* of larger efforts that also address other levels of the SEM. Indeed, many of the programs in Bangladesh that took a health education approach combined this with other components, such as income generation, school retention, vocational skills and/or addressing gender or agency. Some of these are described under the other categories in this section, and others are included in the summary of interventions identified in the literature review (Annex 3).

MEDIA PROGRAMS

Media programs can be quite varied, encompassing community media, digital and social media, and multimedia campaigns. The Bangladesh media landscape is diverse, with traditional forms, such as street theater or "miking" with loudspeakers still popular, while there is simultaneously rapid growth and uptake of digital media. This is especially true in urban areas, where television and social media are popular sources of information. The broad range of media approaches identified in this review speak to this diversity.

Examples from Bangladesh

- UNICEF's Icchedana multimedia campaign consisted of a 26-episode television series targeted to adolescents and parents that followed the lives of four adolescent girls and aimed to educate communities about the consequences of child marriage. The series was accompanied by billboards, advertisements, and other supporting media, as well as social and community mobilization activities in districts with high levels of child marriage. Icchedana is now on its third season. (Adolescent age range targeted: 10–19)
- Dosh Unisher Mor, a community radio program, hosted a weekly, 15-minute program for adolescents, which facilitated discussions on puberty, SRH myths and misinformation, pregnancy, child marriage, and GBV. The program used a standard format that consisted of a mix of drama, songs, and interviews with experts and adolescents. (Adolescent age range targeted: 10–19)

- UNICEF launched two digital/mobile apps: an app for adolescents on physical and mental health and a gaming app using the popular figure of Meena to provide information on gender and child protection.[4] (Adolescent age range targeted with health app: 10–19; Age ranges targeted with the app featuring Meena: children aged 6–9 and older siblings)
- Konnect is a website/web portal developed particularly for adolescents in communities with limited access to the internet and digital technologies. It provides educational support as well as recreational activities (gaming, videos) and job skills development. Konnect hosts Alapon Live, which connects young people to real time psycho-social and mental health support from experts through videos. Konnect's Facebook page, "Konnect Café," is another virtual platform where adolescents can seek information and mental health support. Konnect proved to be a critical resource during the extended period of school closures due to COVID-19 to ensure adolescents had access to education programs, and continues to be an important source of information, education, and awareness creation for adolescents in rural and hard-to-reach communities. (Adolescent age range targeted: 10–19)
- AdolescentBot was a prototype chatbot piloted in six regions with adolescents attending secondary and tertiary school, who had a mobile phone. AdolescentBot responded to queries on SRH from adolescents and medical personnel. (Adolescent age range targeted: 10–19)

Evidence: Evaluations of media programs often tend to focus on reach, and some do indeed show considerable numbers of users. For example, UNICEF's digital media apps have over 5 million downloads. (49–51) Konnect's Alapon Live reaches 1.6 million adolescents, while its Konnect Café reaches an additional 50,000 adolescents on Facebook. (52) There is also evidence that ability to reach the adolescent age group is high. For example, over 81 percent of AdolescentBot users were aged 10–19, and over a third of all users were aged 10–16. Although, three quarters of users were male, indicating that gender disparities pose a significant challenge for digital media interventions. (53) Notably, these media programs do not report reach for 10-14 year olds, so it is not clear to what degree VYAs are engaging with media content, particularly given that they have less access to mobile phones and internet than older adolescents.(3) In addition, despite promising reach, few media programs go further to evaluate outcomes. UNICEF's Icchedana campaign, which measured change in attitudes, is an important exception. The evaluation found that women and adolescent viewers reported increased disapproval of child marriage but also showed that deeply held gender beliefs were not affected. (54)

Considerations: Media-based programs have the potential to reach large numbers of adolescents (and adults) with high quality information and education on SRH, child marriage, and adolescent childbearing, and can even contribute to norms shifting. The findings from Icchedana demonstrate this, as well as showing the value of complementing large scale media interventions with community engagement strategies that address local drivers of child marriage and adolescent childbearing. Community radio is a useful channel for media-based interventions, as it is widely used in rural areas, which still have less access to television or internet, and plays a vital role in providing information and education to generate awareness among both adolescents and adult caregivers.

Digital media also holds real potential to reach adolescents with information and skills development opportunities; however, it is unclear to what degree VYAs are able to engage with digital media (see Insight 7 for more information on VYA mobile phone access). That said, digital approaches to providing information is a priority of the GoB. For example, the Ministry of Education (MoE) and the Department of Secondary

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[4] ***Meena*** was launched as a South Asian children's TV series created by UNICEF and first aired in Bangladesh in 1993. UNICEF describes Meena as a spirited nine year old girl who braves all odds, whether to go to school, ensure equal opportunities for girls and boys, or to prevent child marriage. UNICEF chose the Meena character for its digital app/video game as Meena is popular and widely known across Bangladesh.

and Higher Education have both embraced Konnect, which now reaches 2.7 million adolescents, enabling the participation of students across many educational institutions. (55) Given the increasing access to smartphones, especially for boys, digital apps and chatbots are also showing potential to provide easy access to physical and mental health information and services for adolescents. In particular, AdolescentBot, although only a prototype, revealed that there are high levels of SRH misinformation among adolescents and suggested that chatbots can be easily deployed to counter misinformation or to provide information where adults and parents are reluctant to do so. However, mobile app interventions need to be carefully designed considering whether VYAs can safely access the technology and with a strong focus on gender given the disparity between boys and girls in ownership and use.

Our review of media approaches did not find any documentation of costing considerations for scale, as most project evaluations focus on reporting process-related outputs, complemented by qualitative data. Many key informants observed that media-based interventions such as these have a limited implementation timeframe, are dependent upon the support of donors, and are rarely established within existing institutions or programs, even if the projects demonstrate positive or promising outcomes. Konnect appears to be an exception: originally launched in 2018 as an online-based educational platform, it now hosts 30,000 verified knowledge products, including online academic classes, academic books, psychosocial and life skills educational materials, and continues to expand its offerings to adolescents.

CURRICULUM-BASED PROGRAMS

Common forms of SBC curricula for adolescents include comprehensive sexuality education (CSE), life skills education, or girls' empowerment. Curricula usually consist of a pre-determined set of activities that address priority learning objectives, implemented chronologically over a set period of time (e.g., once per week for 10 weeks). Curricula are often implemented in schools, clubs, small groups, or "safe spaces" (e.g., small groups that meet in a predetermined safe location).

Examples from Bangladesh

- BALIKA adapted Population Council's "It's All One" curriculum to develop 54 activities that allowed girls to explore concepts such as gender, rights, diversity and tolerance, and to promote critical thinking by discussing gender roles, family power dynamics, and the gendered division of labour. The "It's All One" curriculum, which was developed for educators and facilitators to work with adolescents across a wide range of such geographic and cultural settings, was adapted for the Bangladesh context, incorporating a stronger focus on child marriage and practices such as dowry. (Used with unmarried girls aged 12–18)
- "Choose a Future!" is Plan International's life skills curriculum which is part of its Better Life Options and Opportunities Model (BLOOM). The curriculum teaches young people about sexual and reproductive health, nutrition and hygiene, self-esteem and self-efficacy, life skills, civic responsibility, and gender relations and it has been adapted and used all over the world. Plan International adapted and implemented select modules from "Choose a Future!" to complement the MoE's approved curriculum as part of its Advancing Adolescent Health Project. (Used with adolescent girls and boys aged 10–19)
- "Choices" is Save the Children's gender-focused curriculum for VYA boys and girls that aims to create positive social and behavior change, challenge girls' and boys' views on restrictive gender norms, promote gender equity, increase aspirations and agency, increase understanding of puberty, and encourage dialogue with peers and family members to improve gender attitudes. It was initially evaluated for impact in Nepal and a version adapted for Bangladesh was implemented through Save the Children as well as through MOMENTUM Country and Global Leadership with local partners in 2021

with over 600 VYAs. For more information about Choices and its companion interventions, Voices and Promises, see the case study in this report. (Used with adolescent boys and girls aged 10–14)

- The Gender Equity Movement in Schools (GEMS) program is a school-based intervention to promote gender equitable norms and attitudes. The GEMS curriculum has been adapted for Bangladesh and it includes sessions on gender, violence, bodily changes, relationships, emotions, communication, and conflict resolution. For more information about GEMS, see the case study in this report. (Used with adolescent boys and girls aged 12–14)

Evidence: The Population Council's BALIKA project tested three iterations of an intervention developed based on the "It's All One" curriculum against a control and found that interventions that complemented the curriculum with either tutoring support to help girls remain in school or livelihood skills training were able to delay marriage among girls aged 16–17, and that marriage rates declined by one-third across all project sites.(56) Contraceptive use did not increase, and our review did not find any reported reductions in adolescent childbearing. Adolescents exposed to "Choose a Future!" reported positive changes in knowledge and attitudes including a strong interest in delaying marriage and childbearing, but the project reported no changes in child marriage, childbearing, or contraceptive use among participants. (57) "Choices" was piloted with VYAs in Bangladesh over a short time period, which did not allow time to observe any outcome-level changes, although exposure to the curriculum catalyzed reflection and changes in how VYAs understood gender privileges and puberty. (58)

Considerations: Ideally, SBC programs will use curricula that have been well evaluated and demonstrate the ability to achieve measurable change against a desired outcome. Indeed, most of the programs identified in the literature review and mapping, including the three listed above, were based on evidence-informed curricula that support adolescents to develop agency and facilitate the development of life skills, such as communication or decision-making. In particular, there is a large body of global evidence supporting the effectiveness of CSE and a well-defined set of factors that contribute to this effectiveness (see, for instance, those from the United Nations Educational, Scientific, and Cultural Organization [UNESCO]) (59) that can be informative not only to CSE, but to other SRH curricula as well).

In theory, such approaches are well positioned for scale in Bangladesh as the MoE has had a mandate since 2013 to provide CSE in all public schools for grades 6–10 (approximately ages 11 and older) to address puberty, adolescent pregnancy, violence, HIV, mental health, and risky behaviors. CSE is increasingly accepted as a global best practice and it is effective at improving knowledge and supporting adolescents to adopt healthy behaviors, provided teachers adhere to basic principles in terms of content and delivery (e.g., learner centeredness), and that teachers receive adequate and appropriate training. (60) However, a 2018 review of CSE in Bangladesh found that there were multiple implementation challenges, and that insufficient information was provided on menstruation, gender norms, or GBV. (61) While many NGOs implement some form of CSE in their programs, their scope and coverage is often quite limited, and it is often difficult to secure and sustain the participation of adolescents. In validation of this, community consultation and Solutions Workshop participants agree that, while parents are often supportive of CSE, there are often significant content gaps as a result of instructors avoiding "sensitive" topics due to social/normative taboos around SRH. This is an indication of the political, religious, and cultural factors that can make it difficult for schools to effectively implement CSE or for the government to support it at scale.

MULTI-LEVEL SBC INTERVENTIONS

Globally, and in line with best practice, ASRH programs are increasingly implementing SBC interventions that work across multiple levels of the SEM. These programs engage not only adolescents but their families and communities in a range of activities that encourage critical reflection on gender norms and account for the multiple social and institutional factors that influence VYA knowledge, attitudes, behaviors, and norms.

Examples from Bangladesh

- BALIKA implemented a community-based approach, establishing BALIKA centers in primary schools where educational and skills development activities were implemented with small groups of unmarried adolescent girls aged 12–18. A four-arm study, all girls received 144 hours of training on life skills and gender, using the "It's All One" curriculum. Additionally, girls in one arm received education and tutoring support while girls in a second arm received livelihoods training. The third arm received only the curriculum, while the last arm was the control group. BALIKA also conducted outreach to and hosted small group meetings for parents, community groups, local leaders, and teachers to secure their support for girls enrolled in BALIKA. (Adolescent age range targeted: 12–18)
- Nobo Jibon was also a community-based approach that utilized "safe spaces" where adolescents met regularly to participate in small group discussions led by trained peer educators on SRH, gender, and empowerment. Select girls received additional financial literacy and income generation support. Another group of unmarried girls aged 15–17 received an allotment of cooking oil every four months, provided they remained unmarried. (Adolescent age range targeted: 10–19)
- Tipping Point Phase Two (also called Tipping Point Plus) implemented weekly, gender synchronized, education sessions with adolescents using the "Choose a Future!" curriculum and included an intervention to address social norms. This included 18 monthly sessions for parents, outreach to religious and other community leaders, and training for community members on the influence of social norms. (Adolescent age range targeted: 10–16)
- Choices, Voices, Promises implemented 12 sessions with VYA boys and girls, using the "Choices" curriculum. The program held six "Voices" sessions with parents, where parents listened to audio testimonials to catalyze reflection and action on VYA gender and health topics. Community members and leaders participated in six "Promises" sessions using visual posters to catalyze discussion and commitments to uphold gender equality. See the Choices, Voices, Promises case study in this report for more information. (Adolescent age range targeted: 10–14).

Evidence

Both BALIKA and Nobu Jibon reported outcome level changes as a result of their interventions. BALIKA reported that all participants demonstrated increased knowledge of SRH, MHM, HIV, sexually transmitted infections (STIs), and FP. BALIKA was able to delay marriage among girls aged 16–17, and marriage rates declined by one-third across all sites. Girls aged 14–15 who received educational support to remain in school also reported lower rates of marriage compared to the other study arms, providing additional evidence for the importance of helping VYAs remain in school. Overall, there was little difference in outcomes between the arms that received additional support, although they implemented different complementary interventions. (56)

In the Nobo Jibon program, adolescents who received the cooking oil incentive reported significant reductions in child marriage and adolescent childbearing, with 19 percent of adolescents under the age of 18 less likely to be married compared to the control. There was also a 7 percent decline in adolescent childbearing among girls who received the incentive. The effects of the incentive were most pronounced among girls who began receiving cooking oil at age 15, with this group showing a 12 percent decline in

adolescent childbearing. Exposure to the educational sessions reduced adherence to traditional gender norms but had no effect on child marriage or adolescent childbearing. (62)

Tipping Point Plus reported that girls were more assertive and demonstrated more equitable gender norms and improved SRH knowledge; however, they could not report any measurable changes in rates of child marriage or adolescent childbearing. Although they cited a 63 percent reduction in the "hazard" of child marriage and observed that adults seemed to be more open to listening to adolescent girls.(63)

While evaluation of Choice, Voice, Promises in Bangladesh is not yet available, evidence from Nepal showed measurable improvements in gender equitable attitudes and behaviors among VYAs and their parents. VYAs exposed to the intervention had three times higher odds of disagreeing with norms that boys who help with chores are considered weak and had two times higher odds of expressing their hopes and dreams to their family. VYAs were more likely to tell their parents that they want to remain in school, and parents were more likely to believe that child marriage is harmful to communities. (19,20)

Considerations: Multi-level programs are increasingly seen as a key to improving VYA SRH knowledge and behaviors and fostering more equitable gender norms among both VYAs and the social reference groups who reinforce existing norms. As earlier noted, interventions to improve VYA outcomes must meaningfully engage with parents, in-laws, husband, community leaders, and social systems that influence VYA lives to provide these stakeholders with information about the consequences of child marriage and early childbearing. Additionally, engagement with these group must address gender inequitable norms that perpetuate practices, such as limiting the mobility of girls, school dropout, and sexual harassment/"eve teasing." Gender synchronized strategies are key: boys are affected by gender inequality but may also perpetuate harmful gender norms unless they are provided with opportunities to reflect on their impact on the behaviors and outcomes of both girls and boys.

The interventions considered in this review showed mixed results. Overall, programs reported improved knowledge among adolescents as well as some normative shifts among VYAs, caregivers, and stakeholders. BALIKA was able to reduce rates of child marriage, while Nobu Jibon reported declines in both child marriage and adolescent childbearing. Program implementers, however, were also confident that normative shifts were occurring through other programs, even if it was not possible to document and measure these changes over the life of the intervention, which may have been too short to achieve significant, measurable change. Despite these promising findings, we would argue that none of these programs are ready to scale, without more robust evidence of cost and effectiveness, especially among different VYA populations and in different geographies.

INSIGHT 4: SBC programs face constraints in effectively working across levels of the SEM to address determinants.

The Global Context section pointed to the global evidence in support of SBC interventions that work across multiple levels of the SEM, as VYAs are rarely, if ever, primary decision-makers about their lives. Nearly all key informant interview respondents agree that SBC programs need to play a role in strengthening the enabling environment for ASRH and concurred that the SEM provides an appropriate framework for this effort. In particular, respondents in the research activities, especially those in the community consultations, noted that working solely at the individual level (e.g., to build knowledge and skills, shift individual attitudes, or support empowerment) was not sufficient. They called for greater focus on social context, including families and community.

However, resources are constrained, and respondents in both the key informant interviews and mapping process noted that there is a lack of technical capacity to design, implement, and monitor programs that are implemented across multiple levels of the SEM. The literature review found that only a few organizations documented dedicated efforts to involve families and key community members, such as husbands and mothers-in-law. Likewise, this was not widely mentioned among respondents in the key informant interviews or mapping interviews. Four respondents mentioned reaching parents, three cited both teachers and community leaders, two mentioned health workers, and another two cited family members.

Key informants and organizational respondents uniformly agreed that SBC programs as currently implemented are too short to achieve any measurable or significant change.[5] The short duration of most programs also suggests significant challenges in the ability of programs to implement robust activities across the multiple levels of the SEM. Approximately half of the respondents believe that short time frames for SBC programs mean that critical determinants, such as poverty, social insecurity, girls' safety, and social/gender norms, are addressed inadequately or not at all. Where efforts are made to reach other levels, they are often met with challenge. For example, interview respondents noted that while they engage in dialogue with community leaders they wonder whether their efforts have had any effect on their beliefs and attitudes. Instead, programs may choose to focus their activities on adolescents, rather than broader community actors, to be able to report on the numbers of vulnerable adolescents reached with information and skills development opportunities as evidence of programmatic success.

Better engagement with a broader set of communication actors would likely be facilitated through broader use of systematic community engagement and participatory approaches to foster community ownership and sustainability of programs, while increasing their relevance to communities. However, several respondents mentioned that many SBC programs are "top-down," and noted how this can limit their acceptability in conservative or hard-to-reach communities. Only two organizations in the literature review and six out of the 22 organizations interviewed for organizational mapping discussed the use of participatory approaches to develop and/or improve SBC programs, highlighting their efforts to conduct joint assessments, engage in community dialogue and support collective problem solving. In particular, there is space for greater adolescent and youth participation in policy formation; accountability; and program design, implementation, monitoring, and evaluation. Adolescent participants from youth-led organizations who took part in the Solutions Workshops repeatedly expressed their desire and willingness to be more meaningfully involved in both policy and program design and conveyed that they were not given a full seat at the table despite their skills, interests, and abilities, as well as the direct relevance of the issue to their lives.

INSIGHT 5: Strategies that address social norms and related determinants of adolescent childbearing are largely absent in current VYA SBC activities.

Consultation participants strongly articulated the powerful influence of social and gender norms on adolescent childbearing and child marriage. Both key informant interview respondents and mapping interview respondents were also aware of the importance of these normative factors. This is very much in

[5] Of the 17 programs identified in the literature review, seven did not specify an implementation time frame, three programs reported a three-year implementation period, two reported two years of implementation, and two more mentioned a one-year period of implementation. Only one program reported six years of programmatic implementation, while two other programs were implemented for very short durations of six months and nine months.

line with the recommendation in the Global Context section of this report, which calls for SBC programs that take a norms-shifting approach to change the inequitable gender norms driving child marriage and adolescent childbearing.

While recognitions of the important role of norms is strong, it was noted by respondents of this research that efforts to address social norms are not very robust and are mostly limited to awareness creation at the community level. They cite resource and technical capacity as constraints. Organizations appear to lack understanding of, or resources for, implementing activities that go beyond awareness creation to those that can demonstrably shift social norms, especially at the community level. Respondents feel this is compounded by the fact that most SBC programs are of short duration, making it difficult to do much more than awareness creation, much less measure changes in social norms or health and behavioral outcomes. Mapping respondents also voice concern that many of the methods currently used to create awareness and shift social norms (e.g., courtyard meetings, traditional media, such as street theatre or cultural activities, outreach to community elites) have shown limited effectiveness. Although few evaluations have been conducted of these types of activities in Bangladesh, making it difficult to assess the effectiveness of these popular approaches. Despite these constraints, there is optimism that social norm change is occurring, with mentions of positive shifts towards more open discussions of menstrual hygiene and condom use, less discrimination towards girls, and greater willingness to talk about the costs and benefits of child marriage.

LIMITED MEASUREMENT OF SOCIAL NORMS

Three programs identified in the literature review reported efforts to measure changes in social norms. Only one of them, Icchedana, reported changes in social norms, citing increased disapproval of child marriage among parents and adolescent girls (54) (see Insight 3 for more details on Icchedana). The other two programs reporting efforts to measure social norms could not cite measurable changes in social norms or in rates of child marriage, but both reported a belief that change was occurring. One project reported a 63 percent reduction in the “hazard” of early marriage, and stated girls were displaying more assertive behaviors, more equitable gender norms, and greater SRH knowledge. (63) A second project was confident that they had influenced the enabling environment and initiated a process to achieve normative change to discourage child marriage and adolescent childbearing, although no data could be presented to validate this assertion (possibly due to the fact that measurement of social norms is still a relatively new practice). (64)

The limited number of evaluations of social norms change among the programs reviewed is not surprising given that social norms measurement is widely recognized as a complex. While a number of tools and frameworks for social norms measurement have emerged in recent years (65–67), organizations may not have the capacity or resources to adapt and apply such tools to their programs. The constraints around measurement are further discussed under Insight 8 later in this report.

Respondents are also keenly aware of the challenges in measuring the impact of complex, multi-sectoral SBC programs on adolescents, including shifting social norms, and note that there is limited organizational capacity to conduct the high-quality evaluations needed. Quality surveys are seen as hard to implement, and there is a perceived lack of technical competencies to design and administer appropriate data collection activities with adolescents and VYAs. Evaluation activities are often outsourced to other organizations.

ENGAGING MEN AND BOYS

It is well established that shifting inequitable gender norms requires engaging men and boys, and nearly all respondents echoed this importance. In particular, they noted the need to engage men as key reference groups that uphold social norms and as the main decision-makers in families related to childbearing. Yet, it was widely agreed that it is difficult to reach men. Of the programs identified in the literature review, four programs saw parents as a secondary beneficiary, but only one program specifically mentioned fathers, a second mentioned husbands, and a third identified boys. Nearly all key informant interview respondents and mapping interview participants agreed it was difficult to reach fathers, although it was commonly observed that it is easy to engage mothers, especially mothers of VYAs. Several key informants discussed attempts to organize courtyard meetings specifically for men or to organize clubs and discussion groups for fathers, but found it was easier (although perhaps less efficient) to reach men at tea stalls and bazaars.

Reaching VYA boys is also critical to laying the groundwork for long-term changes in gender norms and gender roles that could affect outcomes later in adolescence and adulthood. Although interview respondents commented that boys are easier than men to reach and recruit to participate in SBC programs, only three programs identified in the literature review mentioned reaching both boys and girls as primary beneficiaries. Several respondents also suggested that although it is easier to reach boys in comparison to girls, it is difficult to sustain their interest and participation in existing programs.

INSIGHT 6: SBC programs addressing adolescent childbearing and child marriage are not consistently intervening where the need is greatest.

Table 7 shows the childbearing and child marriage prevalence in each division, along with the number of organizations addressing adolescent childbearing or its drivers present in that division. The three divisions with the highest prevalence of adolescent childbearing are Rajshahi (33.6 percent), Rangpur (29.1 percent) and Khulna (26.3 percent) (note that these are also the divisions with the highest prevalence of child marriage). In comparison, the divisions with the highest concentrations of organizations with active implementation (Dhaka, Chattogram, and Rajshahi) have lower prevalence of adolescent childbearing, except in the case of Rajshahi.

Table 7: Prevalence of adolescent childbearing and child marriage and organizational presence by division[6]

Division	Adolescent childbearing prevalence* (%)	Child marriage prevalence* (%)	Number of organizations implementing in division (n=58)
Dhaka	22.2	48.6	35
Chattogram	22.4	44.1	22
Rajshahi	33.6	66.7	22
Mymensingh	23.4	52.2	19
Rangpur	29.1	58.0	19
Barishal	21.7	55.6	19
Khulna	26.3	61.9	16
Sylhet	14.8	31.0	14

**Source: MICS 2019*

[6] Note that while this report has largely used BDHS data, MICS data is presented in this section because of its inclusion of district level data.

There is significant district level variation in the prevalence of adolescent childbearing within divisions, hence it is also important to note how organizations are distributed across districts within a division and how that compares to the prevalence of adolescent childbearing. This is presented in Table 8. Note that organizational presence does not always imply that the organizations are programming on childbearing, child marriage, or related issues. The mapping interviews verified whether organizations are working on these issues in these specific geographies. However, the available data for those organizations *not* interviewed as part of this research does not provide sufficient district level detail to discern the programming focus. Hence the final column of the table presents a count of organizations *confirmed to be working on these issues through interviews* (i.e., the number of organizations out of the 22 interviewed, not out of the total 58 in the mapping).

Table 8: Organizational presence in the districts with highest prevalence of adolescent childbearing within each division

Division	District with highest prevalence of childbearing* (%)	Number of organizations in mapping that work in this district (out of total organizations working in the division)	Number of organizations confirmed through interviews to be implementing on adolescent childbearing in this district (n= 22)
Rajshahi	Chapai Nawabganj (56%)	11 out of 22	5
Khulna	Narail (41.6%)	6 out of 16	2
Rangpur	Gaibandha (35.5%)	13 out of 19	5
Dhaka	Manikganj (30.8%)	6 out of 35	1
Mymensingh	Sherpur (29.9%)	6 out of 19	2
Chattogram	Brahmanbaria (27.7%)	5 out of 22	0
Barishal	Barishal (23.5%)	11 out of 19	4
Sylhet	Sunamganj (22.4%)	9 out of 14	4

**Source: MICS 2019*

In Rajshahi, the division with the highest prevalence of adolescent childbearing (33.6 percent), half of the organizations implementing in that division have a presence in Chapai Nawabganj, the district with the highest prevalence within Rajshahi Division. In Rangpur, the division with the second highest prevalence of adolescent childbearing, more than two-thirds of organizations implementing in the division have presence in the highest prevalence district (Gaibandha). In Khulna division (the division with the third highest prevalence of adolescent childbearing), less than half of the organizations working in the division have a presence in the highest prevalence district (Narail). However, for some of the other divisions such as Dhaka, Mymensingh, and Chattogram, despite the presence of a good number of organizations in those divisions, very few of these organizations are operating in the highest prevalence districts within those divisions. As mentioned earlier, it was only possible to confirm SBC programming to address child marriage and adolescent childbearing for the organizations interviewed as part of this research. Only a handful of them confirmed such programming in the specific districts.

Finally, Agency for All identified the five districts from across all the divisions of the country with the highest prevalence of adolescent childbearing and examined the level of organizational presence from the

58 organizations identified in the mapping (Table 9). These numbers again indicate that organizations are not systematically intervening in areas with greatest need.

Table 9: Organizational presence in top 5 districts with highest adolescent childbearing prevalence in Bangladesh

District (Division)	Prevalence of adolescent childbearing* (%)	Number of organizations present (n=58)
Chapai Nawabganj (Rajshahi)	53.6	11
Narail (Khulna)	41.6	6
Naogaon (Rajshahi)	40.5	10
Gaibandha (Rangpur)	35.5	13
Rajshahi (Rajshahi)	34.8	9

**Source: MICS 2019*

CHALLENGES REACHING COMMUNITIES IN "HOT SPOTS"

The "hot spots" where prevalence is high overlap with populations that programs struggle to engage, either because of challenging geographies (such as hill tracts, *haors*, *chars*, or areas facing climate change impacts) and/or social factors like distrust of outsiders entering communities that have been traditionally marginalized, including the very poor and ethnic minorities. Despite agreement with the need to focus efforts on divisions and districts with high levels of child marriage and adolescent childbearing, nearly all mapping respondents reported difficulties in implementing SBC programs for adolescents, especially VYAs, in these "hard-to-reach" areas. Some of the most often cited barriers are conservative beliefs, superstitions, or suspicions of program staff from other areas that make it very difficult to enter and gain trust. Approximately one third of mapping respondents noted difficulties in securing parental support for adolescent participation in SBC programs, especially VYA girls, in such areas. For example, they shared that parents may refuse to allow their children to participate unless incentives were provided, and that health workers are not always trusted sources of information. Some respondents also believed that local elected representatives and community elites have had little interest in reducing child marriage, and some respondents believe marriage registrars may block efforts to enforce the law against early marriage. The Chattogram Hill Tracts (CHT), *haor* areas of the Sunamganj district in the Sylhet division, and *char* lands of Gaibandha and other nearby districts are among some of the most hard-to-reach areas in the country. A comparison of the geographical presence of the organizations found in the mapping against these areas indicates a gap in organizations serving these populations.

CHALLENGES REACHING ETHNIC MINORITY COMMUNITIES

Ethnic minorities were also cited as difficult to reach, in part because minorities may live in the remote or hard-to-reach areas described above, but also because of especially high levels of distrust of outside program staff. Key informants note that the lack of resource materials adapted to the linguistic and cultural contexts of ethnic minority communities make it difficult to intervene effectively. There is a limited amount of data on ethnic minorities, although data from MICS 2019 shows a high prevalence of child marriage among ethnic minority groups in the three districts of the CHT (Khagrachari, Rangamati, and Bandarban) ranging from 37 to 54 percent. Data on plainland ethnic minority communities is even less available, making it difficult to plan and implement interventions for these communities. Despite limited data, given the general lack of resources and services within these communities, it is reasonable to surmise that child

marriage and adolescent childbearing are likely issues of concern. Indeed, the five districts with the highest prevalence of adolescent childbearing are also the districts with the highest concentration of plainland ethnic minority populations. Community consultations conducted with participants from the Santal ethnic community in the Chapai Nawabganj district of Rajshahi division further confirm this observation.

CHALLENGE REACHING URBAN SLUM COMMUNITIES

Several informants commented that urban slums are also underserved by SBC programs, many of which are still based in rural areas where child marriage rates have traditionally been higher. The busy urban lifestyle and nature of urban employment also makes it challenging for organizations/programs to reach and/or ensure participation of people from urban slum communities. Platforms that organizations are used to using in rural areas (e.g., courtyard meetings), do not work well in urban contexts. A few of the mapping respondents also mentioned that in urban slums, parents often do not allow young adolescents to participate in program activities, mostly due to safety concerns. School-based programs targeting young adolescents from urban slum communities can help to solve this problem, but such programs are less common in the urban space, and they will not reach adolescents who are not in school.

INSIGHT 7: SBC programs addressing adolescent childbearing and child marriage are not evolving to meet changing conditions.

There was a sense among respondents that programming approaches are not evolving rapidly enough to respond to quickly changing contexts in Bangladesh. As one key informant observed, "(t)hings have changed but we are still implementing the same programs as before." This programmatic stasis is likely to limit the ability of SBC programs to reach VYAs to help them delay pregnancy and leave programs unable to respond to emerging crises or changes that can potentially result in backslides in progress.

According to a 2023 report from UNICEF South Asia, "despite a steady decline in child marriage in the last decade, multiple crises including climate catastrophes, economic shocks and the ongoing fallout from COVID-19 are threatening to reverse hard-earned gains in South Asia." (68) Indeed, many stakeholders engaged throughout this research echoed concerns about such emerging challenges. This section briefly summarizes some of these challenges.

The impact of the COVID-19 pandemic on school closures, economic instability, and a lack of other opportunities for girls besides marriage

The COVID-19 pandemic has exacerbated issues of school dropout and completion, which are drivers of child marriage. Bangladesh's UNICEF representative stated in 2021 that "(d)espite significant progress in recent years, Bangladesh has the fourth highest prevalence of child marriage in the world. COVID-19 compounds the difficulties facing millions of girls. School closures, isolation from friends and support networks, and rising poverty places girls at heightened risk of child marriage."(69) Research conducted by

GAGE to understand the effect of the pandemic on adolescents found that girls reported less support for education and access to learning materials, and more household responsibilities, which led to school dropout, likely putting them at risk for early marriage. (70)

Thirty-seven million Bangladeshi children experienced disruptions in their education due to COVID-related school closures, which not only increased school dropout, but also contributed to increased learning loss, mental distress, and child marriage. (71) Key informant interview respondents shared that COVID-related school closures have had an effect on their ability to implement programs with adolescents, as many organizations rely on schools as a platform to reach adolescents with information and skills development opportunities.

Climate change is contributing to social and economic instability and loss of wealth

Bangladesh ranks as the 15th country globally in terms of climate change risks and impacts on children (72) and climate change is increasingly driving child marriage in Bangladesh, whether through economic insecurity, urban migration, or other factors. (73) Flooding of farmlands and salination of water sources, especially among residents of coastal, *haor*, and *char* communities, and other impacts of climate change are adding to economic uncertainty and challenges to livelihood. Evidence suggests that the negative effects of climate change are contributing to an increase in child marriage, especially in coastal and riverine communities. This is an area that needs to be better understood. A 2020 paper by Asadullah et al. (74) notes that few studies have paid sufficient attention to the correlation between climate change, natural disasters, and weather shocks on child marriage in Bangladesh. To assess the potential impact of climate change and natural disasters in Bangladesh on child marriage rates, the authors conducted focus group discussions and in-depth interviews with child brides and surveyed household members in eight Bangladeshi coastal villages where natural disasters such as flooding, erosion, and salination of water sources are common. Quantitative data showed a positive association between climate events and child marriage. While young women who participated in qualitative data collection exercises did not directly associate natural disasters and climate change in relation to their own marriages, the authors believe child marriage appears to be a coping strategy adopted by households in response to increased vulnerability to natural disasters. (74) Climate change is also driving rural to urban migration, which introduces additional risks and vulnerabilities for adolescents and VYAs.

Rural to urban migration exacerbating issues of social insecurity and safety of girls.

A 2021 paper by Azmi et al. (75) suggests child marriage is increasingly a problem in urban slums, and the paper authors identify multiple social, political, and economic drivers of child marriage in urban informal settlements in Bangladesh. Climate change is spurring rapid rural to urban migration and a World Bank report projects that 13.3 million Bangladeshis will be displaced mostly to urban slums by climate change factors by 2050. (76) Although cities provide economic opportunities, they are also sources of risk, especially for adolescents, and a report from Girls Not Brides observes that, "'climate change refugees' are often forced to live in impoverished and desperate conditions," which can further drive child marriage as a coping strategy. (73)

As already discussed, education is an important protective factor, and while school is free in rural areas, public schools in cities are often inadequate or unsafe, and parents may be forced to enroll their children in private schools, which are not free. Many parents simply cannot afford private school fees, and since many families prioritize boys' education over girls', girls in urban settings may be forced to cut their schooling short, which increases their vulnerability to child marriage. Social insecurity and lack of safety for girls in urban settings was cited by nearly all respondents. Findings from the community consultations in a Dhaka

slum also reinforced poverty and security concerns as the main drivers for child marriage, leading in turn to adolescent childbearing. During consultations in the urban slum, both VYAs and adult participants discussed the need for technical education and training for girls to tackle family poverty/economic hardship. They also expressed the need for social safety net support, including financial support to continue girls' education. Participants also conveyed the heterogeneity of slum residents, in terms of employment and financial status. Those working on a daily wage/day labor basis are considerably more vulnerable, in general, than their neighbors with salaried and higher paying jobs.

Rohingya Refugee Influx

Studies indicate that the Rohingya humanitarian crisis contributes to economic instability in the Cox's Bazar area, exacerbated by unequal access to humanitarian aid and distribution of resources. Many communities experienced a dramatic decline in socio-economic status as wages dropped due to an influx of labor and price hikes in staple goods. A major impact of the refugee crisis has been on schools: many teachers have resigned from schools to work with humanitarian organizations, and in several instances, military personnel have displaced children from schools to set up temporary operations and storage facilities to manage the crisis. A combination of economic instability and school dropout, as well as the vulnerability of Cox's Bazar to climate disasters, has the potential to increase child marriage rates among the host community, although most attention is currently focused on the equally critical issue of child marriage among Rohingya girls. (77)

Consultations with adult Bengali members of the Cox's Bazar host community indicated that the host community does perceive these issues as impacting child marriage in the area. They described a perception that child marriage is common in the Rohingya culture, and they have continued to maintain this practice in Bangladesh. Participants also perceived that this may be further encouraging the practice in the host community as well. Although these observations may be exaggerated due to distrust or tension between communities, the perception that there is a linkage between the issues is itself an important concern to address in programming.

Revision to the 1929 marriage law

The 2017 revisions to the 1929 marriage law introduced an exemption for girls to marry at age 16 with parental permission. This is contributing to an increase in forgeries of birth certificates so that younger adolescents can marry, with limited oversight or prosecution of this practice. Several key informants mentioned that this revision posed challenges to their ability to educate communities about the importance of delaying marriage until age 18, especially since the law is poorly enforced. Several respondents observed challenges in working with traditional marriage registrars, who are reluctant to look for or call out forgeries of birth certificates. The issue of birth certificate forgery was also cited as a common problem by the community consultation participants across locations.

Changing landscape of communication technology

Respondents across our research activities agreed that current programs are not keeping pace with the rapidly evolving media, technology, and information landscape. Bangladesh, like the rest of the world, has seen a rapid expansion in use and access to mobile phones, internet, and social media. This is true especially in urban areas where mobile phone ownership among adolescents is expanding rapidly; although there are significant gender disparities, with girls lagging behind in ownership. In urban areas, for example, 17.2 percent of boys aged 13–14 have mobile phones, compared to only 3.1 percent of girls. In rural areas, 13.7 percent of boys report owning a mobile phone compared to 2.5 percent of girls. (34)

Increasing access presents opportunities to reach VYAs in new ways. For example, Chatbots and other artificial intelligence (AI) can be used to engage young people around contraceptive use, sexual practices, relationships, and other stigmatized or taboo SRH topics in a non-threatening, anonymous way. However, as noted earlier, gender disparities must be considered. As digital access and tools are expanded, program developers must be cognizant of the potential for inequities in access. (53)

Interventions also need to be aware of and responsive to distrust or fear of new media among potential users. Participants in consultations among Dhaka slum residents, for example, raised concerns that adolescent girls were using mobile phones and/or social media to form "love relationships" independent of their parents, which sometimes led to marriage without family consent. SBC programmers also had concerns, with some interview respondents stating belief that VYAs should be discouraged from using digital technologies, observing that adolescents are likely to be exposed to harmful information that leads to "illicit relationships," or to cybercrime. It should also be noted that there are valid concerns about misinformation, which led some respondents to express skepticism about the quality and reliability of information obtained from social media.

Organizational respondents and key informants were keenly aware of both the opportunities offered by these new technologies, as well as the potential challenges or safety concerns. Key informant interview respondents felt that it was imperative that SBC programs make more effective use of the expanding range of available and emerging technologies lest programs fall behind or be seen as irrelevant in a changing environment. However, respondents also pointed to the need for greater technical support and training to understand, plan for, and navigate both the opportunities and the risks, and expressed a need and desire for capacity strengthening for greater and more effective use of digital communication technologies.

INSIGHT 8: A lack of data, learning, and evidence on VYA SBC programming in Bangladesh constrains development of programs and policies to address adolescent childbearing.

GAGE has generated a significant amount of information on key aspects of VYA's lives in Bangladesh in relation to education and learning; bodily autonomy, integrity, and freedom from violence; health, nutrition, and SRH; psychosocial well-being; voice and agency; and economic empowerment, but routine data on VYA SRH is less available. The government's National Strategy for Adolescent Health (NSAH) 2017-2030 observes that, "Bangladesh does not have any nationally representative data which assesses knowledge levels on SRH and rights among the adolescent population." (78) VYAs are not captured in national surveys, such as the BDHS, which only collect data from married women aged 15–49. While the MICS provides a range of data on children aged 5–17, SRH data is only reported for adolescents aged 15–19. There are national surveys including the Household Income Expenditure Survey (HIES), the Labor Force and Child Labor Force Survey, Education Household Survey, and the Urban Health Survey that cover this age group as members in the household roster, but these surveys do not gather information on SRH.

Programmatic data is a potential source of information, but few SBC programs conduct robust monitoring and/or evaluations that measure behavioral outcomes or health impacts among adolescents or VYAs. Most organizations confine their measurement and evaluation activities to reporting output data, such as the numbers of adolescents reached (although data is rarely disaggregated by age), complemented with qualitative data from focus group discussions or key informant interviews. Respondents also acknowledge that most SBC evaluations are conducted in response to donor requirements, with limited available funding. Since the perception is that donors deem programs to be successful when they reach large numbers of adolescents, this contributes to a tendency to focus on outputs over outcomes.

A program is seen as successful if it reaches many people, such as the campaign that secured one million pledges against early marriage….
Key Informant Interview

Respondents are also keenly aware of the challenges in measuring the impact of complex, multi-sectoral SBC programs on adolescents, including shifting social norms, and note that there is limited organizational capacity to conduct the high-quality evaluations needed. Quality surveys are seen as hard to implement, and there is a perceived lack of technical competencies to design and administer appropriate data collection activities with adolescents and VYAs. Evaluation activities are often outsourced to other organizations.
Four programs in the literature review appear to have conducted high quality evaluations: one project conducted a four-arm cluster randomized trial; (56) a second conducted a cluster randomized trial to test two different approaches; (62) a third conducted a three-arm, mixed methods study; (63) and a fourth conducted a baseline survey complemented with qualitative data collection for which the endline is pending.(79) As noted above, only two of these evaluations reported outcome level change in rates of early childbearing and child marriage; although, again, the endline on the fourth evaluation is pending. Several respondents suggested that there is need for better evaluations across the field, as well as a more coordinated effort to translate research and evaluation data into programmatic learning, but they also note that this kind of implementation research is constrained by available funding. Finally, while these evaluations point to the presence of promising approaches in Bangladesh, they provide little data that can inform an assessment of opportunities for scale.

INSIGHT 9: VYAs may fall through the cracks between different sectors and ministries, limiting the ability to scale and institutionalize programming.

The Population Council's 2017 report on ASRH programming in Bangladesh observed a "(l)ack of coordination between stakeholders and collaboration with the government" as well as the importance of "creating opportunities for increased collaboration between the various implementing NGOs and stakeholders working in ASRH and the Government of Bangladesh (as) critical for the advancement and sustainability of ASRH programs."(5) Key informant interviews, organizational mapping interviews, consultations, and Solutions Workshops conducted under this review also validated this observation.

In this section, this report identifies specific ministries and sectors that are important to addressing the SRH needs of VYAs and adolescents and briefly summarizes their current state of programming on this topic. This summary shows that the sectors that currently have the strongest potential for reaching and engaging the VYA age group are health and child protection, reinforcing the need to engage through the MoHFW, MoWCA, and MoE, among others.

Ministry of Health and Family Welfare: Five of the organizations in the mapping interviews expressed that the Directorate General of Family Planning (DGFP) is a key government partner, indicating that organizations view it as relevant to this space. The MoHFW, and the DGFP in particular, has a mandate to

implement the NSAH and prevent adolescent childbearing through their SRH service delivery and SBC. Though the NSAH includes adolescents aged 10–19 and explicitly mentions provision of comprehensive SRH information and SRH services to support delays in adolescent pregnancy, there is little mention of contraception or family planning as means of delaying adolescent childbearing.

The MoHFW has a large service delivery infrastructure that extends to the doorstep of the community, as well as considerable community mobilization and engagement capacities. Information can flow from the national level to the community level within a very short time through this infrastructure. Outreach workers, such as Family Welfare Assistants under the DGFP and Health Assistants under the Directorate General of Health Services, play a crucial role in providing health education and information through door-to-door visits. However, information from the key informant interviews and a review of the MoHFW website indicate a gap in the strategy and its implementation. Their ongoing interventions with VYAs are not quite addressing ASRH, and instead are found to primarily focus on provision of iron and folic acid supplements and other nutrition services, menstrual hygiene management, and generating awareness on pubertal changes. Further, there is need for capacity development of this workforce to effectively deliver SBC interventions, which can help address the problems of adolescent childbearing and child marriage at the community level.

Ministry of Women and Children's Affairs: Currently, VYAs are perceived by respondents in this research to fall largely under the jurisdiction of the MoWCA, which has a mandate to prevent child marriage and promote child protection. Indeed, 16 organizations that we spoke to as part of the organizational mapping interviews identified the MoWCA as their key partner. The MoWCA's leadership on child marriage is notable; however, it does not have an explicit focus on VYAs and does not aim to delay adolescent childbearing. Further, a 2014 Save the Children Bangladesh analysis of the MoWCA programs from a child right's perspective found few programs for children under age 18, with the majority of the MoWCA's activities focused on women's development. (80) At the time of the assessment, only four services for children were listed among the 27 services provided by the MoWCA. A review of the ongoing initiatives on the MoWCA website indicates that the situation has not changed significantly since then. Despite less emphasis on services for children, the MoWCA does have a strong existing infrastructure of more than 15,000 youth clubs that operate in different parts of the country, including more than 3,000 adolescent clubs with an age range that does include VYAs, especially those aged 12–14. These clubs are mandated to motivate adolescents and other community members to adopt positive behaviors for improving health and well-being, among other issues. The MoWCA supports these clubs to employ a mix of media and outreach modalities, community mobilization, and provides capacity development support to participating adolescents to empower them to advocate for their needs effectively. Unfortunately, most of these clubs are not as active as they could be. Nonetheless, they represent an existing platform that could be re-activated in collaboration with other local organizations to mobilize communities and build the agency of VYAs.

Ministry of Social Welfare: In addition to the above ministries, seven organizational respondents also mentioned the Department of Social Services (DSS) under the Ministry of Social Welfare (MoSW) as a ministry partner. Little detail was provided on the VYA-relevant efforts that DSS is supporting, although the respondents highlighted DSS supported youth development centers as a platform for engagement. MoSW maintains a toll-free hotline for children facing violence, abuse, and exploitation.

Ministry of Education: The MoE, which has the mandate to promote education and to provide school health information and services, has a clear role to play in promoting both education outcomes as well as

health with VYAs. Nine organizations that we spoke with identified the MoE as a key partner. All secondary schools fall under MoE's Directorate of Secondary and Higher Education (DSHE), and current health programs under the DSHE have great reach among the adolescent age range, although they do not, for the most part, currently focus on SRH or delaying pregnancy. Nonetheless, the extensiveness of this platform positions the MoE to potentially play a stronger role in the delivery of CSE curricula. There is also scope for collaboration between the MoE's Bureau of Non-Formal Education and the DSHE to provide skills development opportunities to both in-school and out-of-school adolescents, including adolescent girls.

INTER-SECTORAL COORDINATION

The fact that these ministries all have relevance to VYAs, but do not all prioritize VYAs and adolescent childbearing leads to 1) a dearth of government-led efforts to reach VYAs, which impacts VYA outcomes as well as the ability to scale, institutionalize, and sustain VYA focused programs initiated by non-governmental organizations; and 2) challenges in coordination and harmonization of VYA programs. Research participants across activities highlighted the need for better collaboration and collective action between the different institutions and sectors that reach VYAs, which may enable more coordinated, multi-sectoral attention to the multiple variables that increase VYA vulnerability to adolescent pregnancy.

To support such coordination, an inter-ministerial working group on early marriage was established in 2017 and then formalized through a government gazette in 2020. The gazette led to the formation of the inter-ministerial child marriage prevention committee at the national level, but it is currently relatively inactive.

At the community level, respondents in this research recommended strengthening the Child Marriage Prevention Committees to promote cross-sectoral coordination among representatives from the government and NGOs, as well as teachers, youth clubs, and influential community opinion leaders. Similarly, respondents recommended that school management committees and parent-teacher associations be strengthened to better support efforts to keep girls in school, return girls to school (including married girls), facilitate attendance, and monitor risks of school dropout so that problems can be addressed before girls leave school. A specific suggestion was to re-activate local chapters of the *Nari Nirzaton Protirodh* Committee (NNPC) (i.e., Violence Against Women Prevention Committee), formed by the MoWCA. By structure, this committee is headed by the Union Parishad Chairman and its role is to create awareness about gender-based violence and child marriage by holding monthly, ward-based meetings.

Billah et al. (46), as well as respondents in this research, further recommend addressing capacity gaps in local administrative bodies (e.g., *upazila* and union parishads) to support implementation of the National Adolescent Health Strategy and the National Plan of Action to End Child Marriage and to institutionalize and scale SBC programming for VYAs, their families, and communities. In addition to planning and budgeting for key actions to promote delayed marriage and adolescent childbearing, local administrative bodies also have unique ability to enforce legal birth registration and ending the practice of forged birth certificates.

HIGHLIGHT

BARRIERS TO IMPLEMENTATION OF SBC PROGRAMS REACHING VYAS TO REDUCE ADOLESCENT CHILDBEARING

The Insights presented in this report point to a number of barriers that impede the ability of programs to accelerate progress in addressing adolescent childbearing. Although they have been discussed throughout this report as they relate to specific insights, it is critical to consider these barriers comprehensively as an inter-related set of factors that together limit the collective impact of SBC initiatives and investments to reach VYAs and delay childbearing. A summary of these barriers is provided here for easy reference. The focus of this summary is on barriers to improving SBC program quality and constraints to the replication or scale of promising approaches and best practices for reaching VYAs.

BARRIERS IN THE PROGRAMMING ENVIRONMENT

- The funding environment is not conducive to programming with and for VYAs. Respondents perceived that there is little donor interest in funding VYA programming as VYA's are not considered to be at risk for or vulnerable to poor SRH outcomes.

- There is a lack of coordination across the many sectors and ministries that have mandates and existing platforms and infrastructure for addressing VYAs and/or ASRH issues, leaving untapped potential for effectively reaching this age range.

- Climate change, humanitarian crises such as the influx of Rohingya refugees, rural-to-urban migration, and health crises such as COVID-19 are creating rapidly changing conditions that exacerbate drivers of adolescent childbearing and child marriage. Organizations lack data to inform necessary shifts in programming and may not be able to adapt programming sufficiently.

SOCIAL AND NORMATIVE BARRIERS

- Social norms, conservative beliefs, and lack of trust in outsiders constrict ability of implementers to enter and engage with communities, especially among ethnic minorities or in remote areas. Communities may be especially protective when it comes to VYAs, constraining the ability of implementers to directly engage this age group.

- The topic of delaying pregnancy can be seen as inappropriate to address with unmarried adolescents, and delaying pregnancy among married adolescents conflicts with prevailing social norms regarding pregnancy within the first year or marriage. Instead, implementers often perceive it be more feasible to focus primarily on prevention of child marriage as a means to delay childbearing; however, this focus alone is not sufficient for sustained progress on adolescent childbearing.

PROGRAM DESIGN FACTORS

- Programming for VYAs is not prioritized due to perceptions of limited SRH needs in this age range, assumptions that their needs are addressed by broader adolescent programming, or emphasis on child marriage programming with adolescents over direct programming with VYAs.

- The short duration of programs is insufficient to effectively implement multi-level approaches or to achieve measurable change, especially on normative issues. As a result, critical determinants like poverty, social insecurity, girls' safety, and social gender norms are not addressed.

- Program approaches tend to emphasize "top down," didactic, information-based approaches, and do not adequately use participatory approaches, especially those inclusive of adolescents and youth leadership.

- Few programs effectively and systematically involve men and boys. Implementers cite challenges in engaging men. Although boys are easier than men to reach initially, it is difficult to sustain their involvement in programs.

- Many programs focus on keeping girls in school; however, lack of viable employment pathways is likely to constrain impacts of these efforts.

CAPACITY CONSTRAINTS

- Organizations face a lack of technical capacity to design, implement, and monitor programs that work across multiple levels of the SEM. Findings from the mapping interviews indicate that few organizations are implementing with broader community actors (parents, teachers, community actors) at a level that is needed.

- Organizations cite resource and capacity constraints and a lack of knowledge or skills to develop programs that go beyond awareness creation to address social norms more broadly.

- Organizations feel a need to embrace and innovate around use of new technologies and communication platforms but desire skill building to support this.

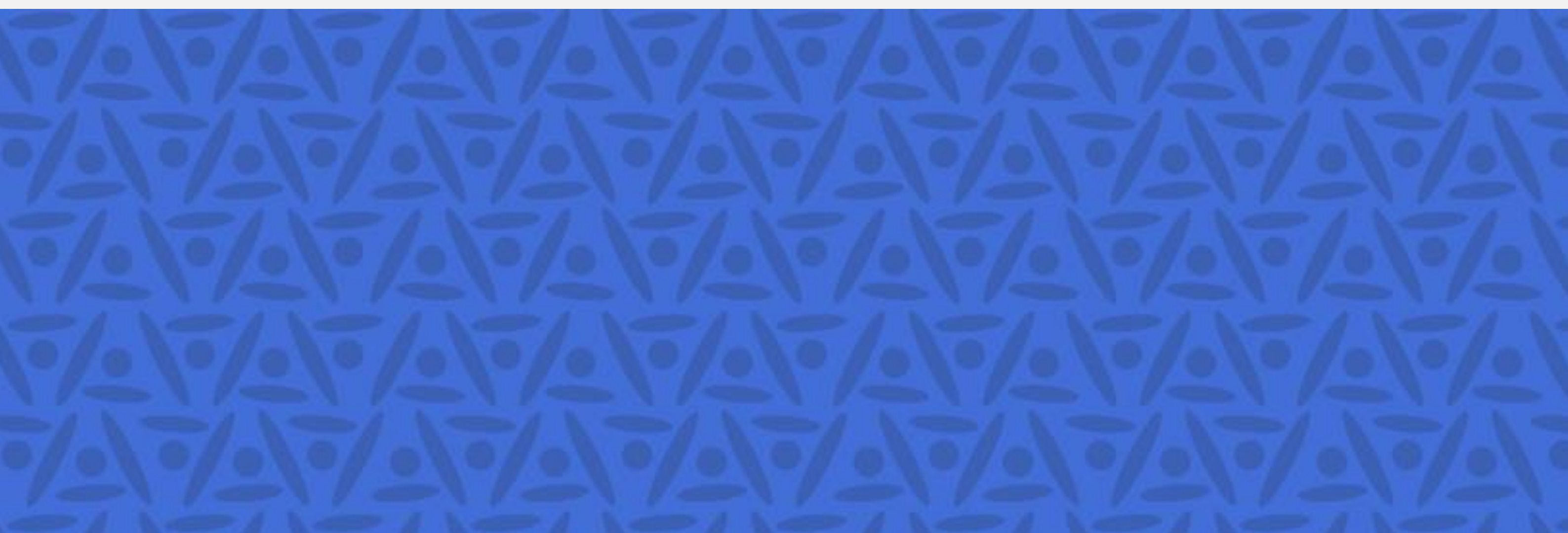
- Organizations see the need for greater focus on evaluation, especially outcome level studies, but cite lack of resources, time, and capacity to conduct such research. In particular, there is a need for focused capacity building around social norms measurement.

GEOGRAPHIC FACTORS

- There is a misalignment between the divisions and districts with the highest prevalence and the areas where organizational implementation is concentrated. Furthermore, many organizations continue to prioritize implementing in rural areas, though the need is expanding in urban areas.

- Implementers cite challenges in programming for VYAs in "hard-to-reach" areas, especially in ethnic communities, poor areas, hill tract areas, and areas like *haors* and *chars* affected by climate change. Challenges include conservative beliefs, suspicion of outsiders, and lack of materials available in relevant languages.

- Child marriage and adolescent childbearing are of increasing concern in urban slums. Yet these areas are underserved, with many organizations still based in rural areas where issues such as child marriage and adolescent childbearing were traditionally concentrated.



RECOMMENDATIONS

Findings from this research and input from stakeholders in the Solutions Workshop informed the development of recommendations for action aligned to each of the key insights presented in the previous section (Table 10). Each recommendation is discussed in greater detail below.

Table 10: Programmatic Insights and Priority Recommendations for Action

<table>
<tr><th>Insight</th><th>Recommendation</th></tr>
<tr><td>Insight 1: Very few interventions tailor strategies to reach VYAs, especially those aged 10–12.</td><td>Recommendation 1: Increase investment in programs and strategies to intentionally reach VYA boys and girls to lay the foundation for delayed marriage and childbearing.</td></tr>
<tr><td>Insight 2: While some interventions directly address delaying pregnancy, more focus on health education or child marriage.</td><td>Recommendation 2: Increase programmatic emphasis on delaying adolescent childbearing, including with married VYAs.</td></tr>
<tr><td>Insight 3: Most interventions fall into one of four intervention types but show limited impact on key outcomes and data needed to consider scale-up is slim.</td><td rowspan="3">Recommendation 3: Design and implement VYA SBC programs that work across all levels of the SEM, in alignment with global and national evidence and promising practices.</td></tr>
<tr><td>Insight 4: SBC programs face constraints in effectively working across levels of the socio-ecological model (SEM) to address determinants.</td></tr>
<tr><td>Insight 5: Strategies that address social norms and related determinants of adolescent childbearing are largely absent in current VYA SBC activities.</td></tr>
<tr><td>Insight 6: SBC programs addressing adolescent childbearing and child marriage are not consistently intervening where the need is greatest.</td><td>Recommendation 4: Prioritize VYA SBC programming in areas with the greatest burden and ensure programs reach adolescents most vulnerable to child marriage and adolescent childbearing.</td></tr>
<tr><td>Insight 7: SBC programs addressing adolescent childbearing and child marriage are not evolving to meet changing conditions.</td><td>Recommendation 5: Innovate and learn about new strategies to engage VYAs within the changing context and conditions of Bangladesh</td></tr>
<tr><td>Insight 8: A lack of data, learning, and evidence on VYA SBC programming constrains development of programs and policies to address adolescent childbearing.</td><td>Recommendation 6: Increase routine and systematic data collection with VYAs to better understand their lives, practices, and evolving needs.

Recommendation 7: Conduct implementation learning, research, and evaluations with a focus on scale and institutionalization of VYA SBC programs in Bangladesh.</td></tr>
</table>

Insight 9: VYAs may fall through the cracks between different sectors and ministries, limiting the ability to scale and institutionalize programming.	**Recommendation 8**: (Re)invigorate and formalize cross-sectoral collaboration and coordination among government, NGOs, and private sector organizations to operationalize national policies and plans that contribute to reducing adolescent childbearing at all levels of government.
Cross-cutting	**Recommendation 9**: Invest in adolescent and youth leadership and support their agency to advocate for stronger responses to child marriage and adolescent childbearing. **Recommendation 10**: Strengthen capacity of a range of stakeholders in VYA SBC programming to lay the foundation to reduce adolescent childbearing.

Recommendation 1: Increase investment in programs and strategies to intentionally reach VYA boys and girls to lay the foundation for delayed marriage and childbearing.

The review found very few programs that intentionally engage VYAs with tailored, age- and developmentally- appropriate content and strategies. The vast majority of programs target older adolescents or all adolescents without any age segmentation. The GoB and civil society are thus missing the window of opportunity that the VYA age and life-stage presents to improve the life trajectories of young people by developing and improving their knowledge, attitudes, skills, agency, aspirations, and behaviors. Hence, it is critical that donors, NGOs, and government actors in Bangladesh intentionally develop and fund programs and strategies that reach 10–14-year-old girls and boys, and their families, communities, and systems, with evidence-informed interventions (see Recommendation 3 for evidence-informed interventions). To do so, however, will require stakeholders to understand the importance of programming for VYAs.

R1.1 Improve stakeholder understanding of the rationale for working with VYAs and how investing in SBC programming with VYAs can facilitate reductions in child marriage and adolescent childbearing. The VYA life stage presents a unique opportunity to facilitate the development of positive gender, social, and health norms and practices and to address current and emerging health needs and concerns. Despite this, it is a common perception that VYAs are not in need of programs or services. Stakeholders need a solid understanding of the unique needs of this age group and why it is important to reach them, as well as an understanding of the role that SBC programming with VYAs can play in facilitating reductions in child marriage and adolescent childbearing. Systematic and evidence-informed awareness generation and advocacy will be needed, and could include, for example:

- Developing briefs in Bangla that summarize the health and development needs of VYAs in Bangladesh (drawing on retrospective and/or existing data from the BDHS, MICS, GAGE, and smaller studies).
- Conducting local information-sharing events, such as webinars and technical working group meetings, to disseminate local and global evidence of the short- and medium-term impacts of SRH and gender programming with VYAs.

- Strengthening awareness of locally implemented VYA programs, such as GEMS and Choices, Voices, Promises (both included as case studies in the report), to address the perception that intervening with VYAs on topics related to SRH and gender is culturally inappropriate and taboo. These two programs illustrate how thoughtful parent, community, and government engagement conveys the importance of providing age-appropriate health information (e.g., knowing your body, puberty, nutrition) and that building assets, agency, and aspirations among VYAs results in high levels of community acceptance.
- Strengthen community acceptance of interventions by leveraging multisectoral entry points by, for example, integrating SRH and gender into other health (e.g., menstrual health and hygiene, nutrition), education, and child protection strategies that are already reaching VYAs.

Recommendation 2: Increase programmatic emphasis on delaying adolescent childbearing, including with married VYAs.

The GoB recommends delaying first pregnancy to age 20, and this review identified a gap in programming content specifically to delay first pregnancy and adolescent childbearing in Bangladesh. Given that the vast majority of childbearing happens in the context of marriage, it is particularly notable that there is a lack of SRH programming for married adolescents, especially VYAs who are not well reached by existing adolescent programs and overlooked by SRH and MCH programs for married women.

R2.1 Explore and evaluate different strategies to increase the emphasis on delaying the first pregnancy in SBC programs. At present, there is little evidence from previous projects to suggest the most promising approaches. Recently implemented projects, such as Imagine and Shuki Jibon, are identifying and testing strategies to delay the first birth, although their findings have not yet been published in peer-reviewed literature. In the meantime, participants in this research, especially participants in the Solutions Workshops, suggested a number of strategies that could be further incorporated into programs and tested, these include:

- Offering quality pre- and post-marital education and counseling to newlywed couples (including married VYAs) on a range of topics, including the benefits of delaying first pregnancy and how to use contraception to delay the first pregnancy.
- Engaging husbands and mothers-in-law during home visits or through small group discussions around the health, social, and economic benefits of delaying the first pregnancy.
- Expanding access to quality contraceptive counseling and services, including efforts to address contraceptive discontinuation, for nulliparous adolescents through quality improvement of services along with efforts to make public, NGO, and private sector health systems more adolescent-responsive.
- Connecting married adolescents with non-formal and formal education and economic development opportunities that provide an alternative pathway to childbearing and support their ability to contribute to the wellbeing of their family.

Recommendation 3: Design and implement VYA SBC programs that work across all levels of the SEM, in alignment with global and national evidence and promising practices.

Strengthening VYA SBC programs and strategies in Bangladesh to align with the current evidence-base is critical. However, given there are so few projects in Bangladesh that have tailored interventions for VYAs and measurable impacts on VYAs, it is not currently possible to recommend the replication of specific Bangladesh projects/interventions. However, taking the learning and evidence from the projects identified

in this review and the global evidence, it is appropriate to recommend designing interventions in line with a set of well-established best practices briefly summarized here (and described in more detail in the VYA SRH and Gender Program Design Guide).

Both global evidence and learning from projects in Bangladesh, such as BALIKA; Choices, Voices, Promises; GEMS; and the different phases of Tipping Point suggest the importance of employing dedicated interventions across the SEM, engaging VYA boys and girls, their families, communities, and systems/services.

The following recommendations specifically speak to different levels of the SEM, staring with VYAs themselves, moving to parents and family, communities, and the systems level. The final recommendations in this section are relevant across all levels.

R3.1. Reach VYA boys and girls by implementing evidence-based curricula. Evidence suggests that curricula-based, participatory sessions engaging VYA boys and girls through schools or out-of-school small groups/safe spaces can be effective in improving intermediate variables on the pathway to delayed childbearing, such as health and gender knowledge, attitudes, aspirations, agency, and behaviors. Specific recommendations regarding evidence-based curricula include:

- Expand the use of curricula identified in this review that have been contextualized, implemented, and evaluated in Bangladesh for VYAs, such as GEMS, Choices, "It's All One," and "Choose a Future!". Accompany implementation with research to assess possibilities and conditions for further scaling these in the country.
- Adapt and include health and gender content relevant to VYAs in ongoing programs/curricula (which are not currently age-tailored). Specific topics should include: relationships, human body and mind, rights and responsibilities, life skills (such as decision-making, communication), gender, sexuality, puberty, menstrual health and hygiene, reproductive health, violence, and safety. (12) In addition, learning methodologies should be tailored to the developmental stage of VYAs using fun and short activities and concrete examples relevant to their life experiences rather than concepts requiring abstract thinking. To reinforce learnings and support VYAs to generate aspirations, create opportunities for them to interact with mentors and role models.

R3.2 Engage parents and families to improve their knowledge, skills, attitudes, behaviors, and norms. Global evidence is clear that engaging parents must go beyond orienting them on the proposed program and obtaining their approval for their child to participate. Parents and family members need accurate information about SRH to help their children navigate puberty and emerging sexuality; positive parenting skills related to communication, active listening, non-judgement, and non-violent discipline; and opportunities to reflect on and challenge inequitable gender and harmful social norms that drive child marriage and adolescent childbearing. In Bangladesh, programs like Choices, Voices, Promises; Tipping Point Plus; and BALIKA have used different strategies to reach parents and promote this content, including group-based learning and open dialogue sessions for parents. Globally, other programs have implemented training/workshops with parents (e.g., Families Matter!), have conducted home visits with a coach or mentor (e.g., REAL Fathers); and/or have facilitated technology-based training and support groups (e.g., Amaze). These interventions have demonstrated improvements in parent knowledge, skills, attitudes, behaviors, and norms. The selection of which approach to use for a given intervention will depend on where and how parents and family members can best be reached given patterns of work, migration, and roles and responsibilities in the home within the particular community.

R3.3 Engage men and boys, alongside girls and women, in gender synchronized strategies. VYA programs to delay childbirth need to reach boys *and* girls. Boys can be reached through the same strategies described above, namely curricula-based small groups or school-based participatory education on the same topics describe above. But content needs to be tailored to meet the unique needs of boys, such as learning about boys' bodies and how boys experience puberty, how to navigate the increasing expectations they face to prove their masculinities (often in ways harmful to themselves or others), and how to negotiate and shape their future in a way that they do not engage in child marriage or adolescent childbearing. Programs have experimented with whether to combine VYA boys and girls in the same sessions and topics. For example, local partners implementing Choices, Voices, Promises in Bangladesh chose different approaches, with one facilitating small groups of both girls and boys and another holding sex segregated sessions. (58) Both approaches were well-received by VYAs and the community, and evidence from gender synchronized approaches with VYAs suggests that there is a benefit to bringing boys and girls together for play-based activities that help them interact and understand each other's experiences and perspectives. However, many programs find it works best to have some sessions with boys and girls separately, such as those focused on the body or puberty, and have some sessions together, such as those focused on household roles and educational aspirations.

Men, especially fathers and fathers-in-law, should also be engaged through the strategies noted above for families and communities. Notably, many programs in Bangladesh and globally have struggled to engage fathers given they are often out of the house for work or view anything related to parenting as women's responsibility. It is recommended that implementers continue to innovate strategies to engage men where they gather and use media to attract them to conversations and interventions.

R3.4 Go beyond awareness raising to reach communities, including government officials, faith leaders, health workers, teachers, and other influential community members, to shift social norms and strengthen community agency. The majority of SBC interventions that address SRH or child marriage have a heavy emphasis on awareness raising. There is a need for more emphasis on dialogic approaches that promote reflection on prevailing social and gender norms and catalyze change. Many community-based norms-shifting interventions have following the attributes:(81)

- Seek community-level change
- Engage people at multiple levels
- Correct misperceptions around harmful behaviors
- Confront power imbalances
- Create safe spaces for critical reflection
- Root the issue within the community's own value systems
- Accurately assess norms
- Model and promote positive norms

Some programs identified in this review used community-based norm shifting strategies, such as facilitated small group dialogues using videos or poster to catalyze reflection as well as interpersonal communication interventions coupled with mass media, such as TV and radio. There are a number of global resources on social norms programming that implementers in Bangladesh can use and adapt to implement SBC interventions that shift social norms. Examples include the Social Norms Exploration Tool, which helps to identify the prevailing norms that influence the lives and trajectories of VYAs as well as the reference groups upholding those norms and the "Getting Practical" guidance developed by Breakthrough Action and the Learning Collaborative to Advance Normative Change. Organizations and government institutions can also strengthen, test, assess for scalability, potentially scale elements of the norm shifting interventions

used by programs identified in this review, such as Tipping Point Plus, BALIKA, Choices, Voices, Promises, and Icchedana.

In addition, SBC programs should increase partnerships with communities in SBC program design and delivery. Communities involved in the design and delivery of an intervention experience a greater sense of agency and are more likely to embrace and sustain change. It is recommended that SBC programs incorporate approaches that enable communities, inclusive of adolescents and parents, to identify their own challenges as they relate to VYAs and adolescent childbearing and propose their own solutions. Such approaches can build on participatory methodologies, like Participatory Action Research, and facilitate the adoption of community engagement frameworks such as the Community Action Cycle.

R3.5 Adopt an adolescent-responsive systems strengthening approach to engage the health sector and foster cross-sectoral partnerships. The findings from this review point to the need for an adolescent-responsive systems strengthening approach that supports changes to each of the health system building blocks to better meet the needs of VYAs as well as older adolescents. Health systems strengthening for VYAs should include:

- Improving provider capacity to offer age-appropriate, non-judgmental services, and counseling for VYAs, related to puberty, mental health, violence prevention and response, vaccines, nutrition, and pregnancy prevention (if sexually active). Provider capacity improvement should include a combination of pre- and in-service training, mentorship, and supervision.
- Expanding service delivery access points to include places that VYAs can seek services, particularly school-based health services.
- Collecting and using age-disaggregated data in the health management information system to see if VYAs are using health services and to improve the services offered based on their needs (see Recommendation 6).
- Ensuring adolescent health services, including for VYAs, are included in national health financing plans and insurance plans and coverage.

In addition, as described further under Recommendation 8, there is a need for increased collaboration within the health sector (for example, between SRH and MCH services) and with other sectors like education and child protection. Improved collaboration may facilitate the implementation of cross-sectoral approaches, such as school-based health services for VYAs, community-based CSE, and improved enforcement of child rights and protection through committees such as the Child Marriage Prevention Committees. Improved linkages between education, economic empowerment opportunities, and social safety nets are also important given evidence from Bangladesh that these structural interventions are critical to delaying marriage.

R3.6 Use multimedia channels in combination with dialogue and community engagement to reach multiple levels of the SEM. Successful multi-media campaigns, like Icchedana, demonstrate the potential of multimedia in informing and engaging VYAs, families, and communities and modeling alternative gender norms and roles. Icchedana combined media with significant community-level engagement in communities with high rates of child marriage, demonstrating the value of implementing multimedia in tandem with other interpersonal communication approaches, such as small group discussions, or complementary activities in schools, and community mobilization.

R3.7 Fund and implement VYA SBC programs for longer duration. Respondents were clear that multi-year programming (even going beyond five years) is critical for SBC programs to make an impact on the lives of VYAs. Multi-year investments are recommended to allow time for behavior and social norm change and to enable adequate support for VYAs as they grow up and transition to marriage and childbearing.

Recommendation 4: Prioritize VYA SBC programming in areas with the greatest burden and ensure programs reach adolescents most vulnerable to child marriage and adolescent childbearing.

Given the decline in child marriage overall in Bangladesh, it is particularly important that government initiatives and organizations working on child marriage and adolescent childbearing prioritize the implementation of programs in child marriage "hot spots." This includes supporting NGOs working on these topics to expand beyond their current programming geographies to implement programs in the highest prevalence districts, as well as investing in organizations already present but not working on these issues to expand their scope when appropriate. Evidence suggests that urban slums are emerging as-child marriage "hot spots" given high rates of rural to urban migration, which is exacerbated by climate-related migration. The literature review, key informants, and Solutions Workshops participants, however, all observed that NGOs mostly work in rural areas, and their presence in urban areas, especially slums, is limited.

R4.1 Invest in supporting NGOs to expand their coverage and/or thematic areas to better serve districts with the highest prevalence of adolescent childbearing. The mapping study conducted as part of this review shows that in many cases, organizations implementing programs on ASRH or child marriage are not concentrated in the districts of highest need within those divisions. These organizations could be supported to expand programming to these high prevalence districts. At the same time, organizations that are already operating in these districts on other issues or sectors could be supported to integrate VYA SBC practices into their programming. For example, organizations addressing climate change could be supported to address child marriage and adolescent pregnancy when it is used as a coping strategy for climate change. Mapping organizations working in such non-health sectors in the high prevalence districts was beyond the scope of this review but would be a starting point for such investments.

R4.2 Target SBC programs to the most vulnerable adolescents and ensure those who are most affected by inequality are reached with appropriate support. Vulnerable adolescents include, but are not limited to, those who are out-of-school, economically vulnerable, from an ethnic minority, and/or living in climate change vulnerable communities. Highly vulnerable adolescents may need more intensive support to mitigate risk factors specific to these communities, such as high rates of poverty. Programs should aim to reach adolescents most affected by inequality with more intensive and evidence-informed interventions, such as curricula-based, small group approaches coupled with multi-level SBC and structural interventions, such as economic and/or education supports, and appropriately tailor strategies to the unique contexts and vulnerabilities of these adolescents. At a minimum, programs should ensure content is available in the languages of ethnic minorities and low-literacy materials are used for out-of-school adolescents. Where possible programs can build on and leverage protective factors, including supportive community leadership, high levels of support for girls' education, or viable pathways to tertiary education or quality employment options.

Recommendation 5: Innovate and learn about new strategies to engage VYAs within the changing context and conditions of Bangladesh.

This review identified notable social, economic, and environmental changes in the Bangladesh context that are shaping the lives of VYAs and present both risks and opportunities, specifically pointing to urban migration, changing media/technology landscape, and climate change. Recommendations related to each are provided here.

R5.1 Increase SBC activities and investment for VYAs in urban settings, especially in slum areas, and identify new approaches for engaging communities in urban contexts. Given the differences between rural and urban settings, program implementers will need new ways to identify and engage the most vulnerable VYAs, their families, and their communities. Approaches used in rural settings do not always translate to urban environments, and it is cost prohibitive to try to reach all VYAs in densely populated communities. Likewise, typical partners in rural areas, such as agriculture organizations, are less relevant in cities, and approaches such as courtyard meetings or small groups curriculum delivery may be more challenging to implement in densely populated and unsafe urban areas. Specific platforms that are recommended for further consideration in the urban context are listed here, although more testing and evidence specific to these contexts is needed:

- Schools remain an important platform; although school-based approaches would need to be combined with approaches reaching out-of-school VYAs, especially in light of evidence that urban adolescents are more likely to drop out of school than rural adolescents. (82)
- Adolescent clubs are a potential platform. A number of NGOs reported organizing and supporting clubs, which can meet in-person or virtually, a flexibility that may be beneficial in urban spaces.
- Programs should consider new strategies and locations to reach parents and other influential adults—especially men—outside of working hours, such as in markets, stores, and tea stalls.
- Programs should identify and map other sectors and partners that are specifically relevant in urban settings.

R5.2 SBC programs should conduct research on VYA media and technology habits to inform future programming. To keep pace with change, SBC programs must adapt new technologies as they are relevant to VYAs. However, this needs to be done with consideration of factors such as a significant digital divide between urban and rural communities, gender disparities in access and use, and safety and security concerns.

- Research is needed to better understand VYA risks as well as opportunities in digital spaces, to identify barriers to media and technology access especially for girls, and to test online digital approaches for their potential to provide quality information and promote dialogue on SRH and child marriage.
- Research will also need to examine implementation considerations such as cost, potential for scale, and sustainability of using different technology platforms for VYA SBC programs.
- Implementers should be familiar with and follow best practices and global guidance for online child safeguarding. Tools such as We Protect, for example, offer frameworks for online child protection.

R5.3 Develop the capacity of organizations working on climate change to integrate SBC programs for VYAs and community members into existing initiatives. As described under Recommendation 4, given the link between climate change and drivers of adolescent pregnancy, it will be important to identify opportunities to partner with organizations working to strengthen community resilience in coastal

communities, *haors*, and *chars* that are vulnerable to climate shocks to also address child marriage and adolescent childbearing as one of the consequences of and/or coping mechanisms for climate change.

Recommendation 6: Increase routine and systematic data collection with VYAs to better understand their lives, practices, and evolving needs.

The dearth of routine, systematic data on VYAs hampers the ability of the GoB and stakeholders to understand the needs of VYAs and plan appropriate responses.

R6.1 Include VYAs in the national health information system. Though challenging, the GoB should take steps to include adolescents aged 10–14 in the national health information system as it transitions to an electronic system. Not only will this provide insight into the healthcare seeking behaviors of VYAs, it will enable the government to monitor the progress and outcomes of the National Strategy for Adolescent Health among this vulnerable age group.

R6.2 Incorporate VYAs in relevant surveys and include lines of inquiry to assess the SRH of VYAs as well as other important aspects of VYA development. While the BDHS is not likely to adapt their survey instrument and sampling to include VYAs due to funding and methodological constraints, there are other surveys and opportunities to learn more about the lives of VYAs, including their SRH, gendered experiences, exposure to GBV, and mental health. For example, MICS and School Health Surveys could be used to better understand VYAs. Other possible surveys that could be leveraged include the national census and the Bangladesh Adolescent Health and Wellbeing Survey (regrettably, the 2019-2020 survey did not include VYAs, but this should be included in the future).

R6.3 Conduct analysis of existing data to share what is known about the lives of VYAs in Bangladesh. In the absence of inclusion of VYAs in the above-mentioned surveys, existing data from smaller scale studies, such as GAGE, and retrospective analyses of DHS data can help to paint a more detailed picture of the health and gender needs of Bangladesh's VYAs.

R6.4 Encourage use of existing data collection tools tailored to VYAs. A number of projects and organizations have developed and validated data collection tools that are specific to VYAs, including GEAS, GAGE, and USAID's Passages Project. Their use should be encouraged by institutions and organizations that are implementing programs with and collecting data on VYAs.

Recommendation 7: Conduct implementation learning, research, and evaluations with a focus on scale and institutionalization of VYA SBC programs in Bangladesh.

There is a dearth of implementation learning, research, and evaluation results specific to VYA SBC programming in Bangladesh, which limits the evidence available to guide the development of VYA SBC programming to prevent very early childbearing and lay the foundation for delays in adolescent childbearing as adolescents grow up.

R7.1 Evaluate the effectiveness of existing and new VYA SBC approaches and test different implementation strategies and combinations of interventions.

As described in Recommendation 3, the review identified a number of promising intervention approaches that demonstrated evidence of effectiveness on key outcomes, such as reducing child marriage. There were also several VYA SBC approaches that appeared to have the potential to shift norms and lay the foundation for preventing adolescent childbearing, but may not have been implemented over a long enough period to achieve results, or had inadequate funds to conduct a robust evaluation. These approaches should be implemented for longer periods and rigorously evaluated. In addition, it will be important to test new and different strategies to engage VYAs, their families, communities, and systems and answer key research and learning questions that surfaced during the Agency for All review. These questions include:

- What are the specific social norms underpinning adolescent childbearing in different communities of Bangladesh? Do they vary by context, including in urban and rural geographies? Who are the reference groups that uphold those norms? What are the strategies that best target these norms and reference groups? How do program interventions contribute to shifting norms?
- What are different combinations of channels to reach VYAs at scale? Which channels and strategies are most effective in reaching VYAs who are most vulnerable to child marriage and adolescent childbearing?
- What are different interventions to engage parents and family members to improve knowledge, attitudes, behaviors, and norms related to VYA health and gender, child marriage, and adolescent childbearing? What are strategies to overcome challenges in engaging fathers and other male family members? How do these vary by context in Bangladesh?
- What are effective partnerships for VYA SBC programming? What are the implications and impacts for VYAs and their communities of different multi-sectoral partnerships and integration, such as health with economic empowerment or child protection?

R7.2 Assess VYA SBC approaches for scalability and identify pathways for institutionalization and sustainability.

As part of efforts to adapt, replicate, and evaluate models, there should be a deliberate and intentional effort to address scalability and institutionalization of SBC programs for VYAs, including research to:

- Assess intervention effectiveness and cost of different intervention durations and dosages. For example, how many small group sessions are needed with VYAs or what should be the duration of an intervention that results in measurable changes in knowledge, attitudes, and behaviors?
- Use the ExpandNet suite of tools to assess whether interventions are scalable and to develop scale-up plans that include pathways to institutionalization and sustainability.
- Adapt and validate VYA SBC programs in diverse settings in Bangladesh to understand whether and how interventions will perform with different populations and contexts.
- Document the factors that facilitate or impede efforts to implement, scale, and institutionalize VYA SBC interventions, with an emphasis on identifying those approaches that facilitate community and government acceptance of VYA interventions.

R7.3 Apply state-of-the-art participatory research methods, VYA-specific research instruments, and social norms research tool.

Globally, investments in programming and research with VYAs and with social norms more broadly has resulted in a range of tools and methodologies that can be adapted and used in Bangladesh. These include:

- Participatory research methods that allow adolescents, including VYAs, to engage as equal partners in the design of research and learning and as data collectors, analysts, and interpreters of the research. This increases adolescents' agency in shaping understandings of their own realities and ensures

adolescents themselves inform future programmatic decisions. See, for example, the VYA participatory research conducted by the Passages Project in the Democratic Republic of Congo. (83)

- Publicly available research questions, tools, and methodologies that have been developed by GEAS and GAGE, as well as participatory qualitative methods for VYAs developed by the Institute for Reproductive Health at Georgetown University. (19,20)
- Guidance, tools, and trainings on how to best identify and measure social norms, particularly as they relate to VYAs. As noted under Recommendation 3, the suite of materials developed by USAID's Passages Project to advance understanding of social norms and to monitor and evaluate social norms are useful resources to adapt and apply in the Bangladesh context.

Recommendation 8: (Re)invigorate and formalize cross-sectoral collaboration and coordination among government, NGOs, and private sector organizations to operationalize national policies and plans that contribute to reducing adolescent childbearing at all levels of government.

Comprehensive and cross-sectoral approaches are needed to ensure the health, education, and social support needs of VYAs are met. In particular, collaboration and coordination across multiple ministries is needed at national, division, district, and community levels. A coordinated implementation of relevant GoB policies and strategies across ministries may contribute to the implementation of more integrated programming. This section presents some specific recommendations towards that end.

R8.1 Reinvigorate national coordination groups, technical working groups, and networks that have a mandate to improve VYA health and wellbeing, including the prevention of child marriage and adolescent childbearing. These groups should involve representatives from the Ministry of Women and Children Affairs; Ministry of Education; Ministry of Health and Family Welfare; Ministry of Social Welfare; Ministry of Local Government, Rural Development and Cooperatives; Ministry of Youth and Sports; Ministry of Home Affairs; and, given the concerns over child labor and the lack of economic pathways for adolescents, the Ministry of Labour and Employment. The Ministry of Finance can be engaged to support the mobilization of domestic resources.

R8.2 Provide technical assistance to lower tiers of government (e.g., *upazilas* and union parishads) to strengthen their capacity to implement national policies.

- Provide coaching, mentoring, and training to local administrative bodies to strengthen their capacity to implement policies and strategies and enforce laws. In particular, this support should assist local government officials to develop contextualized responses to implement the National Adolescent Health Strategy and the National Plan of Action to End Child Marriage and budget for those plans.
- Provide capacity strengthening of local government officials to enforce legal birth registration and help end the practice of forged birth certificates that result in child marriage.

R8.3 Strengthen local standing committees as influential groups in the implementation and enforcement of laws and policies.

- Strengthen Child Marriage Prevention Committees to facilitate more cross-sectoral coordination among local actors, including local government representatives, NGOs, teachers, faith leaders, and influential community leaders.
- Mobilize community-level Union Education Health and Family Planning Standing Committee and Union Women and Children Welfare Standing Committee to play a more active role in improving VYA health, preventing child marriage, and reducing adolescent childbearing. The members of these standing committees often sit on other local committees (e.g., Community Group and Community Support Group), which suggests the potential to cross-fertilize and influence other committees/actors into taking steps to prevent child marriage and adolescent childbearing.
- Re-activate local chapters of the *Nari Nirzaton Protirodh* Committee or NNPC (Violence Against Women Prevention Committee), formed by the MoWCA. Multiple key informants and solutions workshop participants identified these groups and their mandate to both reduce child marriage and violence against women as pivotal to efforts to improve VYA outcomes.

R8.4 Encourage multi-sectoral coordination among NGOs that work with VYAs and their families in different capacities, including health, education, child protection, poverty alleviation, and climate change. Collaboration between VYA-health-focused organizations/partners and partners working to improve the quality and accessibility of education opportunities is particularly important. Equally important is the collaboration between VYA health partners and organizations working to strengthen community resilience to poverty and climate change—two major drivers of early childbearing and early marriage.

R8.5 Support agency of adolescents by ensuring their representation and participation in national and local committees and networks.

- Recruit adolescent representatives through schools and youth clubs, as well as youth-serving and youth-led organizations.
- Develop clear terms of reference for all so actors understand and respect their role.
- Provide adequate support to adolescent representatives to facilitate their active participation, such as linking them to a mentor, or providing stipends to cover transportation and other costs of their participation.

Recommendation 9: Invest in adolescent and youth leadership and support their agency to advocate for stronger responses to child marriage and adolescent childbearing.

This report has already pointed to some specific ways to involve adolescents and youth in actioning some of the recommendations described above. However, in addition to involving adolescents in those specific processes, it is important invest in adolescent and youth leadership more broadly to support the development of their own agency and voice in advocating for stronger responses to child marriage and adolescent childbearing; to hold communities, organizations, and governments accountable to laws, policies, and commitments; and to inform responsive program design. Bangladesh's youth are active leaders and advocates who care deeply about the issues facing their younger peers, and they are increasingly establishing their own organizations and forming alliances to advocate for the rights and needs of adolescents, including for the prevention of child marriage and access to high quality contraception

services. In addition to recommendations mentioned in the sections above regarding, for example, involving them as partners in research and in inter-sectoral coordination committees, it is also recommended to:

R9.1 Allocate funding to youth-led organizations to lead implementation and learning activities related to VYA SBC programming. Funding for technical activities should be coupled with support for organizational and capacity development (see next recommendation). The High Impact Practice Strategic Planning Guide on Meaningful Adolescent and Youth Engagement and Partnership in SRH Programming provides clear steps to foster more equitable partnerships among adult-led and youth-led organizations and stakeholders.

R9.2 Provide funding to establish and/or strengthen platforms for youth and youth-led organizations to advocate for the needs and rights of VYAs and hold their government accountable for action on child marriage and adolescent childbearing at all levels. Existing platforms in Bangladesh, such as the National Children's Task Force, offer clear opportunities for adolescents to engage in advocacy and accountability through structured mechanisms and processes.

R9.3 Support adults to confront their biases around adolescents and develop an improved understanding of the value of working in partnership with young people. Young people are eager to be involved in developing and implementing solutions to child marriage and adolescent childbearing but often struggle to be taken seriously by adults. In addition to building the capacity of youth leaders to actively participate in committees and task forces, it is equally important to ensure they are seen as professional colleagues and partners.

Recommendation 10: Strengthen capacity of a range of stakeholders in VYA SBC programming to lay the foundation to reduce adolescent childbearing.

To implement these recommendations, nearly all respondents identified capacity development needs for organizations and GoB.

R10.1 Use proven capacity development methodologies to improve the organizational, technical, and network capacity of GoB, I/NGOs, and research entities.

Respondents identified the following priorities for capacity development:

- Designing evidence-based VYA SBC programs.
- Implementing strategies to shift social and gender norms and measure changes in norms.
- Innovating and testing new technological solutions with VYAs, keeping gender and child safeguarding at the forefront.
- Conducting VYA specific research methods and survey design.
- Networking and sharing learning and information with other partners, donors, and governments.

Strategies to build technical capacity of organizations and people are well documented in the capacity development literature, and strategies have evolved over the last 15 years. For example, USAID's guidance on Capacity Development 2.0 puts forward an evolution of capacity development strategies focused on meeting the partner's unique needs and helping strengthen their relationships and networks in addition to

technical capacity. These strategies can be applied in the Bangladesh context with an emphasis on improving capacity in the areas noted above. Selected strategies for capacity development include:

- Mentorship and coaching.
- Training or workshops on VYA program design using the VYA SRH and Gender Program Design Guide, as well as on social norm programming using the the resources developed by USAID's Passages project, such as the social norm training curriculum.
- Peer exchange and/or learning visits to ongoing VYA programs.

ANNEX 1

Composition of the Core Consultative Group (CCG)

Name	Designation	Organization	Stakeholder Category
Dr. Monjur Hossain	Assistant Director, MCH Services Unit	Directorate General of Family Planning, Ministry of Health and Family Welfare	GoB
Dr. Ikhtiar Uddin Khandaker	Chair Director, Health Program	Network for Ensuring Adolescent Reproductive Health, Rights and Services (NEARS) CARE Bangladesh	Networks/Platforms/ Alliance
Dr. Mrittika Barua	Assistant Professor and Deputy Director, Centre of Excellence for Science of Implementation and Scale-up	James P. Grant School of Public Health, BRAC University	Academia
Humaira Farhanaz	Programme Analyst	UNFPA	UN
Dr. Jannatul Ferdous	Health Specialist	UNICEF	UN
Michelle Ngirbabul	Health Officer, Office of Population, Health, and Nutrition (OPHN)	USAID	USAID
Dr. Lima Rahman	Director, Health & Nutrition	Save the Children in Bangladesh	I/NGO
Ahmed Al-Kabir, PhD	Founder and Chief Advisor	Research, Training and Management (RTM) International	I/NGO
Dr. Sharmin Sultana	Technical Director/FP Specialist, Health, USAID Accelerating Universal Access to FP (AUAFP)/Shukhi Jibon	Pathfinder International	I/NGO
S. M. Shaikat	Executive Director	SERAC-Bangladesh	Adolescent/Youth-led organizations
Faria Sultana	President of NCTF Satkhira District and member of NCTF Central Committee	National Children's Task Force (NCTF)	Adolescent/Youth-led organizations
Fariha Sultana Aumi	Chief of Operations	Brighters Society	Adolescent/Youth-led organizations

ANNEX 2

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ANNEX 3

Summary of SBC Programs Identified in the Literature Review

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Project Name: Improving Menstrual Hygiene Management for Rohingya Adolescent Girls in Cox's Bazar, Bangladesh **Implementer** -Pathfinder International -Research Training and Management International **Implemented** October 2020-April 2021 **Donor** N/A	-Improve adolescent menstrual hygiene management (MHM) -Improve access to MHM products & services -Address family concerns about MHM	-Cox's Bazar Rohingya refugee camps	**Adolescents** Girls aged 12-17 **Others** -CHWs -Peer leaders	**SRHR** -Early pregnancy -FP -SRH **Other** MHM	**For adolescents** -Peer-led group discussions -Print materials and pamphlets on MHM -Interpersonal communication **For other populations** -Information dissemination -Technical support to CHWs to educate/refer adolescents. **SBC Materials** Developed key messages on MHM developed, printed on leaflets and distributed with sanitary pads	**Humanitarian sector** -Office of the Refugee Relief and Repatriation Commission -International Organization for Migration **Health Sector** GoB family planning services	Program brief did not discuss M&E processes	-Increased knowledge/ normalization of menstruation -Increased use of sanitary pads -Increased understanding that onset of menstruation does not mean ready for marriage	-Challenging to access accurate data in humanitarian settings Family members lack information on MHM. -MHM easily integrated with other SBC programs and services (SRHR, gender, WASH, GBV)
Project Name Tipping Point Initiative (Phase 1) **Implementer** -Care International -Action for Social Development	-Reduce child marriage -Build adolescent agency -Create supportive adolescent-adult relationships -Transform social norms	90 Sunamanj communities in 3 upazilas where child marriage common	-Girls aged 12-16 -Mothers -Fathers -Boys	**SRHR** -FP -Birth spacing -Consequences of early marriage and pregnancy. **Other** -Gender equity -Nutrition	**For adolescents** Education, skills building and peer sharing in 54 "fun centers" or "safe spaces" **For other populations** -Intergenerational dialogue on gender equity in mothers' groups -Community Advocacy	**GBV** Ending Violence Against Women community forums.	**Baseline** Community participatory analysis collected data from girls and boys aged 12-19, married and unmarried. **Monitoring**	-No reported impact but reports state belief project "ruptured" traditional social norms -Reached 7246 adolescents and adults and established 220 mothers' groups -Girls have greater awareness of gender, rights, self-confidence, mobility,	-Involve married girls -Engage fathers and religious leaders. -Address social media skills and mobile phone technology

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
-Jainta Shinnomul Songstha **Implemented** 2013-2017 **Donor** Kendeda Fund	-Grow networks for collective action			-MHM -Life skills/livelihoods -Educational support -Recreation/ sports/theater			Used "Outcome Mapping Tool" for monitoring & learning **Endline** -Qualitative data collection used Sensemaker methodology to document changes attributed to activities. -Did not measure changes in marriage rates or age of marriage.	and knowledge of MHM and nutrition, and report high expectations for future spouse. -Boys less likely to agree with traditional masculine norms -Families support girls' education and less concerned with "honor."	-Support financial literacy and livelihoods -Invest in formal education and skills training as alternative to marriage -Improve services and support access for married girls
Project Name Advancing Adolescent Health **Implementer** -Plan International -Plan Bangladesh -Eco-Social Development Organization -CESDU -World Mission Prayer League (LAMB Hospital) **Implemented** Jan 2016- Jan 2019 **Donor** USAID	-Delay age of marriage and first birth -Improve birth spacing -Improve quality of FP counseling for adolescents -Engage community gatekeepers as adolescent allies	Eight upazilas of Rangpur district	**Adolescents** Boys and girls aged 10-19 (married and unmarried) **Others** Gatekeepers Service providers	**SRHR** - "Adolescent friendly" health services -FP -Birth spacing **Other** -Life Skills -Economic empowerment	**For adolescents** -Curriculum-based small group discussions -Peer/social networking -Interpersonal communication with couples on FP and birth spacing -Referral mechanism for married adolescents **For other populations** -Community advocacy, outreach, workshops for families, religious leaders, decision-makers -Health workers trained in adolescent friendly services and quality assurance. -Health workers involved in small group discussions **SBC materials** -Project used Plan's "Choose a Future" curriculum	Not reported	-One-time cross-sectional comparison. -Endline survey of 11,506 15–19-year-olds in two interventions sites and one control. -Performance Monitoring Plan included, but no details on monitoring process	-307,914 adolescents received life skills training -50,300 adolescents sought services -2,632 adolescent couples educated on birth spacing and FP -53,702 parents and community leaders reached with ASRH information -Most likely to reach unmarried, poor girls or wealthier married girls with no children. -Girls reported increased agency to negotiate contraceptive use once married -Girls aware of legal age of marriage and interested in delaying marriage and childbearing -FP use high (65%) among married girls aged 15-19 for spacing and did not increase. –Belief that A2H influenced enabling environment for normative change to prevent early marriage and childbearing	-A two-year implementation period is insufficient to see outcome level change. -No baseline or endline for comparison or attribution. -Qualitative observations (e.g. reductions in child marriage) not confirmed with quantitative data -Difficult to sustain participation in activities -Essential to involve Muslim religious leaders to reach men.

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Project Name Tipping Point Plus (Phase 2) **Implementer** -CARE - International -Icddr,b **Implemented** 2017-2020 **Donor** Kendeda Fund	Reduce child marriage through building adolescent girls' agency, creating supporting relations and transforming norms	Rangapur District 51 villages (17 per arm) in Pirgacha upazila.	**Adolescents** -Girls aged 12-16 -Boys **Others** -Parents -Religious leaders -Local government -Local influencers	**SRHR** -Sexuality -Contraception -HIV -Child marriage -Puberty **Other** -GBV -Agency -Supportive relationships -Social norms (gender, patriarchy) -Financial literacy and savings and loans groups (girls only)	**For adolescents** -Small group discussions -Gender synchronized approaches -Community dialogue -Social norms intervention -Girl driven movement building/activism **For other populations** -Monthly small group session for parents. -Outreach/training on social norms for community leaders **SBC materials** Project used Plan's "Choose a Future" curriculum	Not reported	**Monitoring** Mixed methods monitoring tracked activities, progress to outcomes and intervention fidelity **Evaluation** -Three arm, mixed methods study of TPI, TPP and control -Baseline survey with 1,275 girls aged 12-16 and endline with 1,123 girls in 2 villages -Cross-sector evaluation of adults aged 25+ (626 at baseline, 634 at endline)	-63% reduction in the "hazard" of child marriage reported -Girls report assertive behaviors, equitable gender norms, life skills and SRH knowledge. -No measurable change in social norms in relation child marriage; perception adults listen to girls' opinions/ideas.	-Implemented during COVID which may have skewed project results. -Need to replicate in different setting with costing analysis
Project Name Rohingya Humanitarian Response Programme **Implementer** UNFPA and multiple NGO/gov't partners in camps. **Implemented** Ongoing **Donor** UNFPA	-Health and life skills education, including GBV for girls -Educate boys to be "champions of change"	Cox's Bazar, refugee camps	**Adolescents** Boys and girls 10-19 **Other** -Caregivers (camp-based and host community) -Community members -Camp workers	**SRHR** Child Marriage **Other** -Life skills -Empowerment -MHM -GBV -Trafficking -Peace Building -Social cohesion -Advocacy	**For adolescents** -Four youth centers -Curriculum based small group discussions -Video games -Sports programming -Help line **For other populations** -Caregivers and camp staff trained to support adolescents -A/V sessions on GBV, child marriage for community members **SBC Materials** -"Girls Shine" curriculum -"Champions of Change" curriculum	Not reported	**Monitoring** Quarterly reporting of adolescents and adults reached by age, sex and type of activities **Evaluation** No	From July –September 2022 program reached: -1,861 girls -2,220 boys -968 caregivers -5,415 community members -6,795 through community mobilization -94 camp staff trained -1,727 used helpline	Situation Analysis only reported project activities and numbers of beneficiaries reached.
Project Name Rohingya Refugee Response in Bangladesh **Implementer** UNHCR **Implemented** Ongoing	-Raise awareness of child marriage and child protection -Provide safe spaces and multipurpose centers for	Rohingya refugee camps	**Adolescents** -Children - Adolescents -Children with disabilities **Others**	**SRHR** Child marriage **Other** -Life Skills -Gender equality -Peer support	**For adolescents** 21 multipurpose centers and clubs for children/ adolescents provide platform for implementation of curriculum **For other populations**	**Child Protection** -UNICEF -Ministry of Social Work/ Dept of Social Services	**Monitoring** Ongoing tracking of activities and # of beneficiaries reached. **Evaluation** No	As of June 2022, program reached: -3,917 adolescents with life skills -6,495 adolescents with psychosocial services -2,205 caregivers with positive parenting training -377 service providers	Situation Report only reported project activities and numbers of beneficiaries reached.

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Donor UNHCR	children and adolescents -Implement gender-specific life skills curriculum in clubs/safe spaces -Provide case management and psychosocial support		-Community members -Committees -Parent groups -Case workers		Training/awareness raising on child protection, referrals, psychosocial support and prevention of sexual abuse, child marriage, child labor, trafficking **SBC Materials** -Translated 2019 Child Protection Minimum Standards in Humanitarian Action into Bengali and Burmese -Reported use of a "Gender specific life skills curriculum" but no details provided			-17,322 adolescents and adults with prevention activities -Established 69 youth centers	
Project Name Nobo Jibon **Implementer** -Save the Children Int'l -Save the Children Bangladesh -Helen Keller International -Int'l Development Enterprise -World Fish Centre -Regional Integrated Multi-Hazard Early Warning System **Implemented** 2010-2015 **Donor** USAID's Multi-Year Assistance Program to address food insecurity	Nutrition project that added a component to reduce child marriage rates especially for girls 15-17, under 20 childbearing and school dropout, and to increase level of last class completed	Six sub-districts and 460 rural communities in South Bangladesh: -Daulakhan -Babuganj -Muladi -Putuakhali -Sadar -Bauphal -Bhola Sadar	**Adolescents** Unmarried, nulliparous girls aged 10-19, both in and out of school. **Other** Pregnant and lactating mothers.	**SRHR** -SRH **Other** -Gender -Empowerment -Nutrition -Numeracy -Literacy -Select girls received financial literacy and income generation support. -Select girls aged 15-17 received cooking oil incentive	**For adolescents** Curriculum-based small group discussions in "safe spaces" led by trained peer educators over six months **For other populations** N/A **SBC Materials** Kishoree Koutha (Adolescent Girls Voices) curriculum	**Community Development, Nutrition and Food Insecurity partners** -Community Development Centre -Gomo Unnuyan Prochesta -South Asia Partnership Bangladesh -Speed Trust	**Monitoring** -Assessed marital status of girls receiving cooking oil every 4 months -Recorded participation in small group sessions and financial literacy/IGA (income generating activities) **Evaluation** -Cluster randomized trial to test incentive vs empowerment activities -Endline conducted 4.5 years post project.	-Women under 18 19% less likely to be married. -All girls receiving cooking oil showed decline in adolescent childbearing. -Longer exposure to incentive increased rate of decline (7% for all girls vs 12% who received 3 years of cooking oil) -Girls exposed to curriculum alone reported less adherence to gender norms but no effect on marriage or childbearing.	-Cooking oil incentive benefited out of school girls in comparison to incentive programs to keep girls in school. -A small economic incentive may be more effective than unenforced laws -Spillover effect to other villages was seen. -Limited effect on low-income girls

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Project Name BALIKA (Bangladesh Life Skills Income and Knowledge for Adolescents) **Implementer** -Population Council -Population Services and Training Centre -Centre for International Development Issues -mPower Social Enterprises **Implemented** Feb 2014 – August 2015 **Donor** Embassy of the Kingdom of the Netherlands	-Generate evidence of what works to delay marriage and childbearing among very poor girls -Assess the influence of social context on intervention effectiveness	Khulna, Satkhiva, and Narail Districts Implemented in 72 unions with 24 unions as control	**Adolescents** Unmarried girls aged 12-18 **Other** -Local leaders -Parents -Teachers	**SRHR** -Contraception -HIV/STIs **Other** -MHM -Gender and rights -Livelihoods -IGA -Education tutoring support -Access to technology (computers, tablets, internet)	**For adolescents** -BALIKA centers established in primary schools and run by young person with support from teacher -144 hours of curriculum based small group discussions for all participants -Complementary activities depending on intervention arm. **For other populations** -Outreach to parents, community groups, local leaders and teachers -Group meetings **SBC Materials** -"It's All One" Population Council Curriculum	**Education** Public schools	**Monitoring** -Unclear from available literature **Evaluation** -4 arm cluster randomized trial (curriculum only; curriculum plus educational support; curriculum plus livelihoods training; control) -11,609 surveyed at baseline and 10,564 at endline. -FGDS and KII at baseline with girls, boys, parents -IDI with girls at endline	-All participants showed increased knowledge of SRH, MHM, HIV, STIs and FP -All interventions delayed marriage among girls aged 16-17 in comparison to control -Little difference in outcomes between Arms 2 and 3 -Girls aged 14-15 in Arm 2 reported lower rates of marriage compared to other arms -No increase in FP use as FP use already high among married adolescents. -In communities that see marriage as collective decision, important to strengthen negotiation abilities -In communities that favor individual decision-making, target illiterate girls at risk of GBV	-Reach girls at an early age and while they are in school -Center adolescent programs on activities that build knowledge/skills specific to age, schooling and marital status and ensure girls' safety -Technology provides a cost-effective "hook" that interests girls and families -Community awareness of child marriage insufficient to facilitate change. -Child marriage less driven by dowry/financial incentives and more by poverty and perception of girls vulnerable to sexual violence or as financial burdens -Child marriage hot spots vulnerable to other risks (e.g., climate change, flooding, migration, displaced populations)
Project Name Choices, Voices, Promises **Implementer**	-Increase quality and reach of gender transformative health programs with VYAs	Satkhira and Dinajpur districts *Now being implemented	**Adolescents** VYAs **Other** -Parents -Community members	**SRHR** Puberty **Other** -Aspirations -Gender norms and equity	**For adolescents** -Curriculum-based small group discussions in schools facilitated by older adolescents -Both mixed sex and sex segregated	Faith-based organizations	**Monitoring** -Participant attendance -Adaptive management approaches **Evaluation**	-VYAs able to reflect on gender and puberty -Parents rethink gendered behaviors and attitudes -Faith-based organizations improved performance on VYAs, gender and outreach	-Older VYAs dominate discussions. -Limited ability of peer facilitators to address complex gender issues

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
-Momentum Country Global Leadership -LAMB -World Renew **Implemented** August 2021 – May 2022 **Donor** USAID *Now being implemented and evaluated by Save the Children with private funding	-Develop model(s) to engage faith-based organizations in VYA programming -Demonstrate measurable improvements in organizational performance -Generate lessons learned/ recommendations for other programs	by Save the Children in Barishal district	-Local government officials		**For other populations** -Courtyard meetings -Small group discussions for parents on gender equitable parenting, delay of marriage, keeping girls in school -Small group discussions with community members investing in and supporting aspirations of VYA girls **SBC Materials** -Choices Curriculum for VYAs -Intervention package for small group discussions with adults		Qualitative Insights from program staff and participants		-Limited male engagement -School closures related to COVID-19 and monsoon season limited overall implementation with both children and adults and level of exposure to interventions
Project Name IMAGINE **Implementer** -Care International -MJSKS **Implemented** 2016-2022 **Donor** Bill and Melinda Gates Foundation	Delay timing of first birth 24 months post-marriage	-Rangpur Division -Kurigram District	**Adolescents** Married girls aged 15-19 **Other** -Husbands -Health care providers -Extended family -Community members -Mentors	**SRHR** -RH education -Puberty **Other** -Life skills -Social norms -Leadership -Vocational/ business skills/IGA/VSLA	**For adolescents** -Curriculum-based small group discussions (girls collectives) -(Small groups also involved mentors and health workers) -Newlywed kits with IEC materials and condoms. -Couples education/ counseling **For other populations** -Workshops for providers on youth friendly services, biases and values. -Interpersonal communication **SBC Materials** -Girls Collective Facilitator's Manual	Project works with private sector in key market systems to support IGA: cotton and jute handcrafts, mobile phone retail/repair, digital/IT services	**Monitoring** -Ongoing monitoring and implementation learning **Evaluation** -Qualitative endline: IDIs, FGDs, group discussion from married girls, husbands, community influentials, health care providers -Non-probability sample of participants -Quantitative endline pending	-Increased support to delay first birth and for girls to participate in IGA. -Girls see a future beyond childbearing, report Increased confidence in seeking SRH services, and satisfaction with health services	-Stigma around delay of first birth still widespread, driven by belief that delaying childbearing/using contraception causes infertility -Girls still have limited agency -Build on interest in birth spacing -Address norms and gender inequities and expand opportunities for girls
Project Name Konnect **Implementer** GoB/MoE **Implemented** -Launched 2018, Ongoing **Donor** n/a	-Disseminate information -Build social capacities -Reduce school drop out	Remote areas, with low bandwidth and limited access to technology	**Adolescents** Boys and girls aged 13-18 **Other** -Parents -Health care providers -Teachers	**SRHR** -ASRH -FP -Child marriage **Other** -Support creativity, capacity, and nurturing	**For adolescents** -Website/portal -Moderated blog on ASRH with live Q&A -Edutainment -Games -YouTube educational sessions **For other populations**	n/a	No information found	-"Alapon Live" reaches 1.6 million adolescents -Konnect Café reaches around 50,000 on Facebook with expert information on Facebook -Website has seen steadily increased traffic	

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
				abilities of adolescents -Develop job skills and facilitate employment -Provide information on addiction, cybercrime, cyberbullying, and extremism	-YouTube educational sessions train health workers to use smartphones to reach adolescents and parents on adolescent health -Platform supports mentorship of providers to improve quality of adolescent services				
Project Name Icchedana **Implementer** -UNICEF -PCI Media -BRAC University James P Grant School of Public Health -Asiatic MCL -Drexel University **Implemented** Launched 2018 **Donor** -Global Affairs Canada -Ford Foundation -ODI	-Change norms that support child marriage -Show social norm changes can be measured -Understand the role of "edu-tainment" in shifting norms -Show transmedia facilitates audience engagement and reaches remote populations	-Program aired nationally -Third season launched in 2022 -Targeted outreach in three districts where child marriage rates are high: Tangail, Kushtia, and Nilphamari,	**Adolescents** Girls and boys with access to/regular use of mobile phones and TV **Others** -Fathers -Mothers -Anyone with access to/regular use of mobile phones and TV	**SRHR** -Puberty -Sexual abuse -Child marriage **Other** -MHM -Harassment -Nutrition -Value of staying in school	**For adolescents** -26-episode TV program used transmedia and enter-educate approaches supported by billboards, signs and ads -Outreach and community mobilization targeted to adolescents and families in high-risk communities **For other populations** Same as for adolescents **SBC Materials** -TV series "Icchedana"	-Ministry of Women and Children's Affairs (MOWCA) -Ministry of Information (MOI)	**Monitoring** -Tracked exposure to messaging and shifts in targeted behaviors and norms **Evaluation** -Longitudinal panel study -Baseline and endline surveys measured level of exposure and degree of normative change .	-Regardless of exposure to Icchedana, evaluation documented declined support for child marriage due to other activities and efforts by donors, INGOs and GoB -Social norm shifts can be measured over time -Increased disapproval of child marriage, but gender beliefs not affected (e.g., a respondent may oppose child marriage but believe it more important to educate boys) -Girls/women had positive reaction to program with mothers more likely to disapprove of child marriage and fathers to report child marriage is discouraged -Adolescent boys believe there is more disapproval of child marriage but report it is still practiced as there are no sanctions or law enforcement	-Endline did not mirror the baseline. -Purposeful selection of sites may limit generalizability of findings -Rapid digital shifts in Bangladesh (e.g., TV viewership is high in urban areas and among housewives and secondary students) and TV reaches wider audience than traditional media -Mobile phone ownership increasing among adolescents
Project Name Dosh Unisher Mor **Implementer** Part of UNFPA Generation	Increase youth knowledge and self-efficacy to seek information on SRH and GBV	National	Adolescents	**SRHR** -Puberty -SRH myths & misinformation -Pregnancy, -Child marriage,	**For adolescents** n/a **For other populations** n/a **SBC Materials**	-Ministry of Education -University of Dhaka (helpline)	**Monitoring** -Reached 140,000 adolescents aged 10-19 in 300 schools, 50 madrasas and 150 clubs	Youth have limited access to trusted sources of information on SRH or GBV. Radio and social media provide this information.	n/a

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Breakthrough Project **Implemented** 2012-2016 **Donor** Embassy of Kingdom of Netherlands				**Other** -GBV -Supported by school and club events, competitions, games, social media, street drama, advocacy and helpline	-100-episode 15-minute radio program -GEMs module in schools		**Evaluation** -In-depth interviews with l12 boys, 12 girls and 12 adults found high approval of content -Several respondents reported acting to prevent child marriage -Respondents better understand danger of early pregnancy		
Project Name Meena: 3-D Gaming app/video game for 6–8-year-olds **Implementer** UNICEF **Implemented** Launched December 2018 **Donor** UNICEF	-Messages on gender, rights, protection, and development -Information on physical and mental health	National	-Children aged 6-8 -Older siblings of children - Adolescents **Other** -Parents -Teachers	**SRHR** unclear **Other:** -Physical health -Mental health -Healthy development -Gender -Child rights and protection	**For adolescents** Entertain and educate using phones/tablets with character of Meena, a nine-year-old girl **For other populations** -Outreach to teachers and parents to support use of app -"Teacher approved" badge from Google **SBC Materials** -Digital app -Video game -Comic books -Animated films -Posters -Discussion and teachers' guides	-Ministry of Education -Public schools	**Monitoring** -5 million downloads -16 million YouTube views -33,000 reviews **Evaluation** n/a	no information	-Available as a free app -UNICEF using apps and games to establish 'digital footing' for social networking
Project Name AdolescentBot **Implementer** Not reported **Implemented** Not reported **Donor** n/a	Examine potential of chatbot for adolescent health education	Rural and urban communities in 6 regions	-Boys and girls aged 10-19, in school -Smart phone users	SRH information and support	**For adolescents** Chatbot **For other populations** n/a	Ministry of Education	**Monitoring** n/a **Evaluation** Surveyed 256 adolescents (76% male, 24% female; 81.6% aged 10-19, 37% aged 10-16) in three schools, two colleges and one university in six regions	Chatbot can provide basic health information to reduce high levels of misinformation.	Provides confidential platform to circumvent taboos

Project Overview	Objectives	Location	Groups targeted	Themes	SBC approaches	Collaborating partners	Monitoring & Evaluation	Results	Key lessons learned
Project Name Adolescent Friendly Health Centers (AFHCs) in Select Government Facilities **Implementer** -UNFPA -UNICEF -GoB **Implemented** Ongoing **Donor** -UNFPA -UNICEF	A hub for adolescents seeking SRH information and services	National	Adolescents	**SRHR** -SRH information -No contraceptive services provided **Other** -RH services (MHM, discharge) -Nutrition -Anemia -Advice	**For adolescents** -Distribution of print materials (pamphlets, etc) -Information dissemination **For other populations** n/a **SBC Materials** Print materials developed by UNFPA and/or UNICEF	-AFHCs integrated into existing health facilities -AFHC guided by GoB and UNFPA s protocols, tools around what makes services "youth friendly"	**Monitoring** n/a **Evaluation** Qualitative study of 10 AFHCs in 5 maternal child welfare centers and 5 union health and family welfare centers in Moulvibazar, Thakukrgaon, Sirajgang, Patukahli and Cox's Bazar	-Low awareness of AFHC and little effort to link to existing SBC or schools -No effort to create awareness among influential adults (teachers) who could refer adolescents -No effort to use local or traditional media to create awareness	n/a
Project Name -Let Us Learn: Ready to Enter Job Market (Part of the Alternative Learning Program) **Implementer** UNICEF **Implemented** 2021 **Donor** World Bank	Prepare out of school adolescents aged 14-18 for labor market	Sylhet	-Girls and boys aged 14-18 -Primary school leavers/out of school -Very poor	n/a	**For adolescents** Six months of classroom instruction and on the job training 4 x per week **For other populations** n/a	-Ministry of Labor -Ministry of Education	**Monitoring** n/a **Evaluation** UNICEF followed 100 adolescents.	-Qualitative data suggests program reduced pressure for early marriage -Parents pleased with the economic benefits of job training for girls	-Ability to generate own income may be pathway to avoid marriage and childbearing -Need to be better able to track marriage and childbearing data in programs in other sectors

ANNEX 4

Key Informant Interview Respondents

Name	Designation	Organization
Dr. Md. Monjur Hossain	Program Manager, Adolescent Health	Directorate General of Family Planning, Ministry of Health and Family Welfare
Md. Latif Mollah	Line Director, Information, Education and Motivation (IEM) Unit	Directorate General of Family Planning, Ministry of Health and Family Welfare
Mohammad Aman Ullah	Deputy Director, Social and Behavior Change Communications (SBCC) Lead	Directorate General of Family Planning, Ministry of Health and Family Welfare (Dhaka district)
Md. Mukhlesur Rahman	Planning Chief	Bureau of Health Education (BHE), Ministry of Health and Family Welfare
Dr. S. M. Mustafizur Rahman	Line Director, National Nutrition Services	Health, Nutrition and Population Sector Program (HNPSP), Directorate General of Health System, Ministry of Health and Family Welfare
Md. Jashim Uddin Khan	Deputy Secretary, Public Health Wing, (Member Secretary)	Health Service Division, Ministry of Health and Family Welfare
Morshed Khan	National Consultant, Adolescent and Youth Participation	UNICEF
Dr. Zeenat Sultana	Program Director	Bangladesh Center for Communication Programs
Dr. Kazi Faisal Mahmud	Country Director	John Hopkins University Center for Communication Programs
Dr. Ikhtiar Uddin Khandaker	Director, Health Program	CARE Bangladesh
Dr. Golam Mothabbir	Senior Technical Advisor, Health & Nutrition	Save the Children in Bangladesh
Dr. Yasmin H Ahmed	Member, Board of Trustees	Marie Stopes Bangladesh
Dr. Zeba Mahmud	Country Manager, Alive & Thrive	FHI 360
Dr. Md. Khalequezzaman	Associate Professor	Bangabandhu Sheikh Mujib Medical University
Dr. Selina Amin	Team Leader, ProNurse Project	Cowater International

ANNEX 5

Mapping of local organizations working on issues related to ASRH

Table 1 presents a division-wise clustering of the 58 organizations covered under the mapping. Please note that the names of several organizations are repeated in the different rows as they operate in multiple divisions of Bangladesh. This is followed by Table 2 which presents detailed information on these organizations (presented in alphabetical order) such as their working locations (district-level), focus areas of work related to VYAs or adolescent childbearing, other sectors of work, age groups covered (focusing on adolescents), whether they are youth-led organizations, and a final column indicating whether the organization was covered by the mapping interviews.

Table 1. Division-wise clustering of local organizations covered under mapping

Division	Organizations Working in the Division
Dhaka	Ad-Din Welfare Center; Aparajeyo-Bangladesh; Association for Prevention of Septic Abortion, Bangladesh (BAPSA); Bandhu Social Welfare Society (Bandhu); Bangladesh Center for Communication Programs (BCCP); Bangladesh Women Health Coalition (BWHC); BRAC; Caritas Bangladesh; Centre for Mass Education in Science (CMES) Bangladesh; Community Participation for Development (CPD); Concern Women for Family Development (CWFD); Dhaka Ahsania Mission (DAM); Family Planning Association of Bangladesh (FPAB); Ghashful; Gono Kallyan Sangstha (GKS); Gonoshasthaya Kendra (GK); HEED Bangladesh; HIV/AIDS and STD Alliance Bangladesh (HASAB); JAAGO Foundation; Kotha; Mirpur Family Planning Project; Nari Maitree; Nari Unnayan Shakti (NUS); Palashipara Samaj Kallayan Samity (PSKS); Population Services and Training Centre (PSTC); Reproductive Health Services Training and Education Program (RHSTEP); Right Here Right Now - Bangladesh Platform; Sabalamby Unnayan Samity (SUS); Samaj Kalyan O Unnayan Shangstha (SKUS); Shimantik; Social and Economic Rights Action Center (SERAC) - Bangladesh; Spreeha Foundation of Bangladesh; Village Education Resource Center (VERC); Youth for Change Bangladesh (YFC-BD)
Chattogram	Association for Prevention of Septic Abortion, Bangladesh (BAPSA); Bangladesh Women Health Coalition (BWHC); BRAC; Caritas Bangladesh; Community Development Center (CODEC); Concern Women for Family Development (CWFD); Dhaka Ahsania Mission (DAM); Family Planning Association of Bangladesh (FPAB); Ghashful; Gonoshasthaya Kendra (GK); JAAGO Foundation; Mamata; Mukti Cox's Bazar; Nari Maitree; Partners in Health and Development (PHD); Samaj Kalyan O Unnayan Shangstha (SKUS); Shimantik; Spreeha Foundation of Bangladesh; Village Education Resource Center (VERC); Voluntary Association for Rural Development (VARD); Young Power Social Action (YPSA); Youth for Change Bangladesh (YFC-BD)
Rajshahi	Association for Community Development (ACD); Association for Prevention of Septic Abortion, Bangladesh (BAPSA); BRAC; Caritas Bangladesh; Centre for Mass Education in Science (CMES) Bangladesh; Concern Women for Family Development (CWFD); Dhaka Ahsania Mission (DAM); Eco-Social Development Organization (ESDO); Family Planning Association of Bangladesh (FPAB); Ghashful; Gono Kalayan Sangstha (GKS); Gonoshasthaya Kendra (GK); JAAGO Foundation; Nari Maitree; Pollisree; Samaj Kallyan Sangstha (SKS); Spreeha Foundation of Bangladesh; Thengamara Mohila Sabuj Sangha (TMSS); Tilottama Voluntary Women's Organization; Unnayan Sangha; Village Education Resource Center (VERC); Youth for Change Bangladesh (YFC-BD)

Division	Organizations Working in the Division
Mymensingh	Aparajeyo-Bangladesh; Association for Prevention of Septic Abortion, Bangladesh (BAPSA); Bandhu Social Welfare Society (Bandhu); BRAC; Caritas Bangladesh; Community Development Center (CODEC); Community Participation for Development (CPD); Concern Women for Family Development (CWFD); Family Planning Association of Bangladesh (FPAB); JAAGO Foundation; Nari Maitree; Partners in Health and Development (PHD); Right Here Right Now-Bangladesh Platform; Sabalamby Unnayan Samity (SUS); Social and Economic Rights Action Center (SERAC) - Bangladesh; Trinamul Unnayan Shangstha; Unnayan Sangha; Voluntary Association for Rural Development (VARD); Youth for Change Bangladesh (YFC-BD)
Rangpur	Ad-Din Welfare Center; Association for Community Development (ACD); BRAC; Caritas Bangladesh; Centre for Mass Education in Science (CMES) Bangladesh; Eco-Social Development Organization (ESDO); Family Planning Association of Bangladesh (FPAB); JAAGO Foundation; Mahideb Jubo Somaj Kallayan Somity (MJSKS); Nari Maitree; Partners in Health and Development (PHD); Pollisree; Rangpur Dinajpur Rural Services (RDRS); Reproductive Health Services Training and Education Program (RHSTEP); Samaj Kallyan Sangstha (SKS); Thengamara Mohila Sabuj Sangha (TMSS); Udayankur Seba Sangstha (USS); Youth for Change Bangladesh (YFC-BD)
Khulna	Ad-Din Welfare Center; Agrogoti Sangstha; Banchte Shekha; BRAC; Caritas Bangladesh; Community Development Center (CODEC); Dhaka Ahsania Mission (DAM); Family Planning Association of Bangladesh (FPAB); JAAGO Foundation; Khulna Mukti Seba Sangstha (KMSS); Nari Maitree; Palashipara Samaj Kallayan Samity (PSKS); Reproductive Health Services Training and Education Program (RHSTEP); SAINT-Bangladesh; Youth for Change Bangladesh (YFC-BD)
Barishal	Ad-Din Welfare Center; Agrogoti Sangstha; Aparajeyo-Bangladesh; Association for Voluntary Actions for Society (AVAS); BRAC; Caritas Bangladesh; Community Development Center (CODEC); Community Participation for Development (CPD); Concern Women for Family Development (CWFD); Dhaka Ahsania Mission (DAM); Family Planning Association of Bangladesh (FPAB); HEED Bangladesh; JAAGO Foundation; Mamata; Palashipara Samaj Kallayan Samity (PSKS); Partners in Health and Development (PHD); SAINT-Bangladesh; Shimantik; Youth for Change Bangladesh (YFC-BD)
Sylhet	Bangladesh Women Health Coalition (BWHC); BRAC; Caritas Bangladesh; Family Planning Association of Bangladesh (FPAB); Friends in Village Development Bangladesh (FIVDB); HEED Bangladesh; JAAGO Foundation; Partners in Health and Development (PHD); Rangpur Dinajpur Rural Services (RDRS); Reproductive Health Services Training and Education Program (RHSTEP); Shimantik; Sylhet Jubo Academy (SJA); Voluntary Association for Rural Development (VARD); Youth for Change Bangladesh (YFC-BD)

Table 2. Detailed information on local organizations covered under mapping

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Ad-Din Welfare Center	• Barishal • Dhaka • Khulna • Rangpur	• Bagerhat • Bogura • Chuadanga • Dhaka • Dinajpur • Faridpur • Gopalganj • Jashore • Jhenaidah • Khulna • Kushtia • Lalmonirhat • Magura • Meherpur • Narail • Nilphamari • Panchagarh • Rajbari • Rangpur • Satkhira • Thakurgaon	**FP, ASRH**	• Health services • Microfinance • IGA	No	unknown	No
Agrogoti Sangstha	• Barishal • Khulna	• Bagerhat • Barishal • Khulna • Satkhira	**Child marriage, ASRH, adolescent childbearing** Community mobilization; Advocacy meeting; Capacity building on SRHR, child marriage, and adolescent pregnancy; life skill/vocational training for IGA to reduce poverty; Community Radio Program for talk-show on child marriage and SRHR (including adolescent pregnancy)	• Good governance • Human rights • Child rights • Climate change • Health and rights	No	12-25	Yes
Aparajeyo-Bangladesh	• Barishal • Dhaka	• Dhaka • Jamalpur	**ASRH**	• HIV/AIDS • Human rights of sex workers	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
	• Mymensingh	• Jhalokathi		• Child trafficking • Supporting victims of sexual abuse and exploitation			
Association for Community Development (ACD)	• Barishal • Khulna • Rajshahi • Rangpur	• Bogura • Chapai Nawabganj • Dinajpur • Gaibandha • Jashore • Joypurhat • Kurigram • Lalmonirhat • Naogaon • Narail • Natore • Nilphamari • Pabna • Panchagarh • Rajshahi • Rangpur • Satkhira • Sirajganj • Thakurgaon	**Child marriage, adolescent childbearing** Forming monthly adolescent groups that try to convince parents against child marriage when informed about specific incidences. Monthly meetings are held with parents and community leaders to raise awareness. Mass awareness programs are also organized, using different media (e.g., Theatre for Development, miking, leaflets, posters)	• Women empowerment	No	15-18	Yes
Association for Voluntary Actions for Society (AVAS)	• Barishal	• Barishal • Patuakhali	**Child marriage, adolescent health** Arranging training sessions, developing IEC materials, and community dialogues at the district/upazila/union level focusing on preventing child marriage for the age groups of 10-14 and 15-19; Social awareness sessions such as courtyard meeting; Individual sessions with unmarried female adolescents on preventing early pregnancy	• Women empowerment • Safe water supply and effective sanitation • Rights for women and children • Legal aid and education • Literacy education for the underprivileged • Education mainstreaming support for out-of-school children	No	10-19	Yes

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
				• HIV/AIDS and STI prevention • Violence against women and children			
Association for Prevention of Septic Abortion, Bangladesh (BAPSA)	• Chattogram • Dhaka • Mymensingh • Rajshahi	• Bhola • Dhaka • Gazipur • Joypurhat • Lakshmipur • Mymensingh • Noakhali • Rangamati	**Adolescent health, ASRH** Group meeting for adolescents aged 10-19 years through trained health workers; orientation for school going adolescents through trained schoolteachers, and for working adolescents through trained community workers	• Youth health	No	10-19	Yes
Banchte Shekha	• Khulna	• Jashore • Khulna	**Child marriage**	• Women and child rights • Water, sanitation, and hygiene (WASH) • Health and nutrition • Humanitarian response/Emergency response and relief distribution • Food security and livelihood • Housing • Microfinance	No	unknown	No
Bandhu Social Welfare Society (Bandhu)	• Dhaka • Mymensingh	• Cox's Bazar • Dhaka • Mymensingh • Rajbari	**ASRH**	• GBV • Capacity building • Policy advocacy	No	unknown	No
Bangladesh Women Health Coalition (BWHC)	• Chattogram • Dhaka • Sylhet	• Chattogram • Dhaka • Narayanganj • Sylhet	**ASRH**	• IGA • HIV/AIDS • MCH	No	unknown	No
Bangladesh Center for Communication	• Dhaka	• Dhaka	**FP**	• Climate change	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Programs (BCCP)				• Democracy and good governance • Public procurement reform • Food security • Education • Anti-trafficking and anti-terrorism • Agriculture • Child protection • Reproductive health • Urban health			
BRAC	• All eight divisions	• All 64 districts	**Child marriage, adolescent childbearing** Courtyard meeting for women; household visits by CHWs; Advocacy and sensitization meeting with community elites; Skill development; IGA training through microfinance and community empowerment program; Coordination, communication and liaison with government and NGOs	• Health • Human rights and good governance • Education • Economic empowerment	No	10-19	Yes
Caritas Bangladesh	• All eight divisions	• Bagerhat • Barguna • Barishal • Chapai Nawabganj • Chattogram • Cox's Bazar • Dinajpur • Gaibandha • Gazipur • Gopalganj • Habiganj • Jashore • Khagrachari	**Child marriage, ASRH** Group-based awareness sessions with adolescents on child marriage and reproductive health issue; Discussion session with fathers' and mothers' groups separately on child marriage and reproductive health	• Employment and income • Food security and housing • Education rights and inclusive quality education • Health education, care and public health services • Disaster response and community resilience • Ecological sustainability • Indigenous people living standard improvement	No	10-18	Yes

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
		• Khulna • Kurigram • Lalmonirhat • Madaripur • Manikganj • Meherpur • Moulvibazar • Mymensingh • Naogaon • Natore • Netrokona • Nilphamari • Pabna • Panchagarh • Patuakhali • Rajshahi • Rangamati • Satkhira • Sherpur • Sirajganj • Sunamganj • Sylhet • Tangail • Thakurgaon					
Centre for Mass Education in Science (CMES) Bangladesh	• Dhaka • Rajshahi • Rangpur	• Nilphamari • Rajshahi • Rangpur • Tangail	**Adolescent health, ASRH, FP**	• Women empowerment	No	unknown	No
Community Development Center (CODEC)	• Barishal • Chattogram • Khulna • Mymensingh	• Bagerhat • Barishal • Borguna • Chandpur • Chattogram • Cox's Bazar	**Child marriage, ASRH, FP** Awareness raising on child marriage using various materials, such as pictures, posters, flashcards, and other visual aids; Organizing mass gatherings using local rallies, dramas, traditional folk songs like *Gombhira*,	• MCH • Child development • Education	No	10-19	Yes

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
		• Faridpur • Gopalganj • Jhalokathi • Khulna • Lakshmipur • Madaripur • Mymensingh • Noakhali • Patuakhali • Pirojpur	puppet shows, *Hoila* (marriage songs) to convey messages and raise awareness				
Community Participation for Development (CPD)	• Barishal • Dhaka • Mymensingh	• Dhaka • Jamalpur • Patuakhali	**Child Marriage, FP** Meeting with community leaders and support groups; motivating adolescents; street drama; meeting with guardians; Community Learning Group; Child-Friendly Local Group; Hotline number for reporting child marriage	• Child protection • Child safeguarding • Women empowerment	No	15-24	Yes
Concern Women for Family Development (CWFD)	• Barishal • Chattogram • Dhaka • Mymensingh • Rajshahi	• Barishal • Chapai Nawabganj • Chattogram • Dhaka • Netrokona • Patuakhali • Rajshahi	**Child marriage, adolescent childbearing, ASRH** Message dissemination through local Cable TV network, leaflet, sticker as IEC materials; street drama; *Jari* song; *Gombhira* in local dialect at *char* areas; conducting tea stall meeting and video show for raising mass awareness on child marriage, and FP issues	• Maternal and infant health • Sustainable health and development	No	15-19	Yes
Dhaka Ahsania Mission (DAM)	• Barishal • Chattogram • Dhaka • Khulna • Rajshahi	• Barishal • Chattogram • Cox's Bazar • Gazipur • Khulna • Patuakhali • Rajshahi	**ASRH, FP**	• Education • WASH • Technical and vocational training • Agriculture • Economic development • Rights and Governance	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
				• Climate Change			
Eco-Social Development Organization (ESDO)	• Rajshahi • Rangpur	• Bogura • Gaibandha • Kurigram • Natore • Rangpur • Thakurgaon	**ASRH, FP**	• Poverty • Empowerment of marginalized community	No	unknown	No
Family Planning Association of Bangladesh (FPAB)	• All eight divisions	• All 64 districts	**ASRH, FP**		No	unknown	No
Friends in Village Development Bangladesh (FIVDB)	• Sylhet	• Habiganj • Moulvibazar • Sunamganj • Sylhet	**Child marriage, adolescent childbearing, ASRH, FP** Adolescent empowerment through club-based activities; cash support provided to victims of child marriage and child labor; meetings with community members and government committees; community dialogues; Interactive Popular Theatre on child marriage; district and sub-district level committees to combat child marriage	• Maternal and neonatal health • Child development • Education	No	10-18	Yes
Ghashful	• Chattogram • Dhaka • Rajshahi	• Chapai Nawabganj • Chattogram • Cumilla • Dhaka • Naogaon	**Child marriage, adolescent childbearing, FP** Mass awareness raising initiatives such as street drama to engage people from different social classes; direct involvement with child groups	• Child protection • Community health • Education • Microfinance • Climate change • Agriculture	No	8-15	Yes
Gono Kalayan Sangstha (GKS)	• Dhaka • Rajshahi	• Bogura • Chapai Nawabganj • Dhaka • Natore • Pabna • Siraganj	**Child marriage, adolescent childbearing, FP**	• Food security and livelihood • Human rights and good governance • Environment and disaster • Human resource development	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Gonoshasthaya Kendra (GK)	• Chattogram • Dhaka • Rajshahi	• Cox's Bazar • Dhaka • Gazipur • Manikganj • Sirajganj	**ASRH, FP**	• Education • Rohingya response program • Agriculture cooperative society • Wood and metal workshop • Driving training school	No	unknown	No
HEED Bangladesh	• Barishal • Dhaka • Sylhet • *Other divisions could not be verified*	• 32 districts across different divisions *(detailed information could not be verified)*	**ASRH, FP**	• Health • Education • Agriculture • Aquaculture	No	unknown	No
HIV/AIDS and STD Alliance Bangladesh (HASAB)	• Dhaka	• Dhaka	**ASRH**	• Livelihood • HIV/AIDS and STI counselling	No	unknown	No
JAAGO Foundation	• Chattogram • Dhaka • All eight divisions have youth volunteers	• Cox's Bazar • Dhaka • Volunteer youth network in 64 districts	**Child marriage**	• Youth development • Adolescent empowerment • Education • Governance/civic engagement • Women empowerment • Climate change	No	unknown	No
Khulna Mukti Seba Sangstha (KMSS)	• Khulna	• Jashore • Khulna	**Child marriage, ASRH**	• Primary health care • Basic and non-formal education • Women empowerment and rights • Climate change and disaster management	No	unknown	No
Kotha	• Dhaka	• Dhaka	**ASRH**	• GBV • Mental health	Yes	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Mahideb Jubo Somaj Kallayan Somity (MJSKS)	• Rangpur	• Dinajpur • Gaibandha • Kurigram • Lalmonirhat • Nilphamari • Rangpur	**Child marriage**	• Livelihood and agriculture • Youth empowerment • Health and nutrition • Governance • Humanitarian assistance • Climate change adaptation	No	unknown	No
Mamata	• Barishal • Chattogram	• Bhola • Chattogram	**Child marriage** School-based awareness programs; community case studies; courtyard meetings; individual and group discussions; mass awareness events such as dramas, puppet shows and video presentations	• Adolescent and child protection • Childcare center	No	9-14	Yes
Mirpur Family Planning Project	• Dhaka	• Dhaka	**FP**		No	unknown	No
Mukti Cox's Bazar	• Chattogram	• Cox's Bazar	**Child marriage** Adolescent club-based awareness sessions and community-level message dissemination on child marriage	• Health and nutrition • WASH • Education • Microfinance • Gender justice and diversity • Disaster, environment, and climate change • Community empowerment • Human rights and legal aid	No	12-18	Yes
Nari Maitree	• Chattogram • Dhaka • Khulna • Mymensingh • Rajshahi • Rangpur	• Chattogram • Dhaka • Kishoreganj • Kushtia • Mymensingh • Rajshahi • Sirajganj • Thakurgaon	**Adolescent health**	• Health • Education • Women empowerment • Human rights and governance	No	unknown	No
Nari Unnayan Shakti (NUS)	• Dhaka	• Dhaka	**ASRH**	• Women Empowerment • Livelihood	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
				• HIV/AIDS prevention			
Palashipara Samaj Kallyan Samity (PSKS)	• Barishal • Dhaka • Khulna	• Chuadanga • Faridpur • Kushtia • Madaripur • Meherpur • Shariatpur	**Adolescent health**	• MCH • Education • Livelihood • Vocational training	No	unknown	No
Partners in Health and Development (PHD)	• Sylhet • Barishal • Chattogram • Mymensingh • Rangpur	• Moulvibazar • Bhola • Cox's Bazar • Gaibandha • Kishoreganj	**Child marriage, ASRH, FP** Family-based services and mass awareness events; training for local-level service providers; advocacy committee; working with community support system to mobilize and raise awareness; use of manual and digital interventions, along with tools for assembling adolescents; involving local government for impending child marriage occurrences; engagement with Upazila Health Complex, Adolescent Health Corner, and Breastfeeding Corner	• MCH • Nutrition • Women-led climate resilience • Midwifery-led health services	No	15-25	Yes
Pollisree	• Rajshahi • Rangpur	• Dinajpur • Joypurhat • Naogaon • Nilphamari • Panchagarh • Rangpur • Thakurgaon	**Child marriage**	• Women empowerment • Gender and governance • Economic empowerment • Disaster preparedness • Climate change	No	unknown	No
Population Services and Training Centre (PSTC)	• Dhaka	• Dhaka • Gazipur	**Adolescent health, youth and adolescent development**	• Population health and nutrition • Gender and governance • Leadership	No	unknown	No
Rangpur Dinajpur Rural Services (RDRS)	• Rangpur • Sylhet	• Dinajpur • Gaibandha • Habiganj	**Child marriage, ASRH, FP** Group-based orientation session with adolescents; school-based sessions for	• Social empowerment • Women's rights • Community health	No	13-19	Yes

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
		• Kurigram • Lalmonirhat • Moulvibazar • Nilphamari • Panchagharh • Rangpur • Thakurgaon	students of class 6-10; day observation; government and NGO coordination meetings; union-based youth forums and adolescent clubs; engaging ambassadors from these forums/clubs to conduct sessions on child marriage, SRHR, and FP issues	• Reproductive health • Legal education • Gender-aware leadership			
Reproductive Health Services Training and Education Program (RHSTEP)	• Dhaka • Khulna • Rangpur • Sylhet	• Dhaka • Gaibandha • Narail • Sylhet	**ASRH** Formation of adolescent groups, parents' groups, teachers' groups, community groups with parents, religious leaders, elites, teachers; orientation sessions and courtyard meetings about SRHR, child marriage, delaying pregnancy, menstrual hygiene for each group; separate session with male and female adolescents at both school and community level	• Maternal health care • Compassionate and respectful care	No	10-19	Yes
Right Here Right Now-Bangladesh Platform	• Dhaka • Mymensingh	• Dhaka • Jamalpur • Mymensingh	**ASRH, adolescent health**	• SRH • Education for youth and adolescents • Increased social tolerance towards gender expressions	No	unknown	No
Sabalamby Unnayan Samity (SUS)	• Dhaka • Mymensingh	• Netrokona • Tangail	**Child marriage, adolescent childbearing** Arranging group meeting, community dialogue, folk song, SMC meeting, parents' and teachers' meeting for discussion on child marriage; group meeting with adolescents facilitated by adolescent ambassadors; tea stall meetings at local market	• Gender • Climate • Livelihood • Education • Health • Food security • Rights • Governance • Networking and advocacy	No	14-19	Yes
SAINT-Bangladesh	• Barishal • Khulna	• Barguna • Barishal	**Child marriage, adolescent childbearing**	• Child rights • Education	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
		• Bhola • Jhalokathi • Khulna • Patuakhali		• SRHR • Climate change and disaster management • IGA • Child Protection			
Samaj Kallyan Sangstha (SKS)	• Rajshahi • Rangpur	• Bogura • Dinajpur • Gaibandha • Kurigram • Lalmonirhat • Natore • Nilphamari • Rangpur • Sirajganj • Thakurgaon	**FP**	• MCH • Livelihood • WASH • Child Protection	No	unknown	No
Samaj Kalyan O Unnayan Shangstha (SKUS)	• Chattogram • Dhaka	• Chattogram • Cox's Bazar • Dhaka • Feni • Madaripur • Narsingdi • Rajbari	**FP**	• Education • Life Skill Education • HIV/AIDS • Child Protection and GBV • Health and nutrition • WASH	No	unknown	No
Social and Economic Rights Action Center (SERAC)-Bangladesh	• Dhaka • Mymensingh	• Dhaka • Mymensingh • Narayanganj • Netrokona	**Adolescent Health, FP, ASRH**	• Human rights • Health service • Legal protection • Education • Livelihood	No	unknown	No
Shimantik	• Barishal • Chattogram • Dhaka • Sylhet	• Barishal • Chattogram • Cox's Bazar • Dhaka • Habiganj • Moulvibazar • Rangamati	**Child marriage, adolescent childbearing, ASRH, FP** Group meeting and individual counselling for married and unmarried adolescents; meeting for mothers and fathers of adolescents, LGB community; video show and street drama for mass awareness; toll free	• Maternal and neonatal health • HIV/AIDS • Tuberculosis	No	10-19	Yes

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
		• Sunamganj • Sylhet	hotline for reporting child marriage; coordination and communication with GOs, LGB, local administration and local elites				
Spreeha Foundation of Bangladesh	• Chattogram • Dhaka • Rajshahi	• Chapai Nawabganj • Chattogram • Cumilla • Dhaka • Naogaon	**Child marriage, adolescent childbearing** Awareness raising session with underserved population, including adolescents and youth group on education, health care, child protection, child marriage, etc.; issue-based training for empowering the marginalized community	• Health • Education • Adolescent development	No	10-25	Yes
Sylhet Jubo Academy (SJA)	• Sylhet	• Habiganj • Moulvibazar • Sunamganj • Sylhet	**Child marriage, ASRH**	• WASH • HIV/AIDS • Education	No	unknown	No
Thengamara Mohila Sabuj Sangha (TMSS)	• Rajshahi • Rangpur	• Bogura • Dinajpur • Gaibandha • Rangpur	**ASRH, FP**	• Education • Livelihood • WASH • Microcredit • Training for IGA	No	unknown	No
Tilottama Voluntary Women's Organization	• Rajshahi	• Bogura • Chapai Nawabganj • Naogaon • Natore • Pabna • Rajshahi • Sirajganj	**ASRH, FP**	• Health • Women empowerment • Mass education	No	unknown	No
Trinomul Unnayan Shangstha	• Mymensingh	• Jamalpur • Mymensingh	**Child and women rights, ASRH, child marriage**	• Livelihood • Education	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Udayankur Seba Sangstha (USS)	• Rangpur	• Kurigram • Lalmonirhat • Nilphamari	**Adolescent health, adolescent childbearing** Using posters and counseling sessions to raise awareness about child marriage; holding family meetings and providing training to children and parents; using Theater for Development (TFD) and dramas for community engagement to promote awareness about child marriage	• Women development • Child rights protection • Gender equality • Education • Governance	No	11-18	Yes
Unnayan Sangha	• Mymensingh • Rajshahi	• Jamalpur • Sherpur • Sirajganj	**Child marriage, FP** Conducting courtyard meetings, community gatherings, IPT shows, drama, *Jari* song, and meetings with mothers and guardians to deliver messages and raise awareness on child marriage; video shows to deliver messages about religion to the Muslim community in *char* areas; counseling to families by community volunteers on child marriage;	• Maternal and neonatal health	No	13-15	Yes
Village Education Resource Center (VERC)	• Chattogram • Dhaka • Rajshahi	• Cox's Bazar • Dhaka • Gazipur • Sirajganj • Tangail	**Child marriage, ASRH**	• WASH • Health • Education • Nutrition • Child protection • MCH • Eye care • Microfinance	No	unknown	No
Voluntary Association for Rural	• Chattogram • Mymensingh • Sylhet	• Chattogram • Kishoreganj • Netrokona	**ASRH, FP**	• Economic and livelihood development • Health and nutrition • Education	No	unknown	No

Organization name	Working Divisions	Working Districts	Focus areas related to VYAs/childbearing	Other sectors covered	Youth-led (yes/no)	Age group covered (years)	Interviewed in mapping (yes/no)
Development (VARD)		• Sylhet					
Young Power Social Action (YPSA)	• Chattogram	• Bandarban • Brahmanbaria • Chandpur • Chattogram • Cox's Bazar • Cumilla • Feni • Lakshmipur • Noakhali • Rangamati	**ASRH** Awareness sessions with school committees; meetings with parents; advocacy for service providers; working with government stakeholders at the advocacy level; using health tracker and tablet for conducting awareness sessions in three languages (Bangla, Chakma and Marma); helpline for information on child marriage; electronic media for drama shows; school-based programs and campaigns to raise awareness about reproductive health, using a peer-to-peer approach; using Rohingya language for SBC activities at Rohingya camp of Cox's Bazar	• Education • Health • Women's rights and good governance • Economic empowerment • Environment and climate change • Disaster risk reduction • Humanitarian response	No	15-18	Yes
Youth for Change Bangladesh (YFC -BD)	• All eight divisions	• 64 districts in Bangladesh	**ASRH, Adolescent health**	• Gender • Climate change • Health • Youth development	Yes	unknown	No

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