Promoting community Health through Social Networks: a Case Study of Adolescent Health Program of North-Western Bangladesh

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Introduction: Bangladesh has made significant progress in health indicators in recent years despite the low level of per capita income. Life expectancy at birth for both males and females has gone up since the 1980s. Infant and under-five mortality, the maternal mortality ratio and fertility rates have also declined considerably (NIPORT, 2011; 2012). According to national health policy of Bangladesh, the provision of primary health care (PHC) services is a public responsibility, and the government is committed to fulfill this role through its own facilities, which are geographically dispersed (MoHFW, 2011a). A well-developed rural health infrastructure exists in Bangladesh compared to urban areas, but they are inefficiently operated, and there is a trend of declining use of public facilities in recent years (Cockcroft et al., 2004; 2007). People rely increasingly for curative care on the private sector, which includes different types of actors. Available studies on the problems of the health care sector focus on proximate causes such as the absence of doctors, incompetence, and indifference of health staff, and corruption related to medical supplies and unofficial fees charged from patients (Cortez, 2006). However, the underlying causes of inefficiency are rooted in the system, which lacks both incentives and accountability. PHC service facilities in Bangladesh are not completely decentralized. This is because of the lack of participation of the local government and the community, particularly in the financial and decision-making processes, in which the central government is directly involved. The government of Bangladesh (GOB) faces challenging times in translating its commitment to adolescent girl's health into results at the community level. Early marriage (before age 18), early pregnancy (before age 20), and poor family planning, particularly in rural areas, threaten adolescents girls' health and well-being. Adolescents are the important segment of the population of our country, have been sufferings from some deficiencies like ignorance about their health, social barrier and prejudices and they have less capacities and skill to take decisions about their future well-being. Consequently, early marriages, pregnancies at immature age and frequent child bearing with very minimum spaces are caused in the communities. Due to the above situations both mother and child fall in a deep risk of life. Sometimes it has been found to delivery steal birth and immature baby, which results a barrier for a healthy nation. In these circumstances Eco Social Development Organization (ESDO)–a well reputed national NGO of Bangladesh with the support of Plan International Bangladesh & USAID has undertaken a project titled "Advancing Adolescent Health (A2H)".

The Country Context: Despite Bangladesh's progressive National Adolescent Reproductive Strategy 2006 (NARS) and the subsequent National Plan of Action (NAP) on adolescent sexual and reproductive health (SRH), the government of Bangladesh (GOB) has faced difficulty translating its commitment to improving adolescent health into effective implementation. Early marriage (before age 18), early pregnancy (before age 20), and poor family planning, particularly in rural areas, threaten adolescents' health and well-being. Plan's 2013 Asia Child Marriage Initiative (ACMI) research report in India, Nepal, and Bangladesh details the severe risks that child bride's face, including higher instances of domestic violence, lower educational and economic attainment, and limited decision-making power around family planning and allocation of household resources. Child marriage also perpetuates poverty, gender inequality, and poor health and development.

Box 1: Key statistics for Bangladesh

1. The world's fourth highest rate of early marriage before age 18, at 65%, 2. The world's highest rate of marriage before age 15, at 29%, 3. 40% of women aged 20-24 giving birth by age 181 - one of the highest rates of adolescent pregnancy in the world, A 61% national contraceptive prevalence rate, though only a 47.1% rate for married adolescents aged 15-19, Adolescent girls aged 15-19 have a higher unmet need for family planning1 (17%) compared to the national average (14%)1, • Only 11% of females and 14% of males aged 15-24 have knowledge of HIV

Although the Child Marriage Act of 1929 set the legal age of marriage at 18 for girls and 21 for boys, the Millennium Development Goal (MDG) Bangladesh Progress Report of 2013 identifies early marriage and poor ASRH as key obstacles to progress, particularly on MDG 5 (maternal mortality). Furthermore, the GOB's revised draft of its 2014 Child Marriage Restraint Act proposed to lower the age of marriage and included a clause that girls can marry at 16 "under special circumstances." The overall lack of SRH is illustrated by key statistics and is easily confirmed anecdotally throughout Bangladesh. Despite this challenging context, however, opportunities to create positive change abound. By leveraging national government commitment to improve adolescent health, empowering local champions for adolescent rights at the individual and institutional level, and building on successful initiatives spearheaded by ESDO, transformed the underlying social norms that perpetuate early marriage and pregnancy.

The Local Context: Socio-cultural gender norms and taboos around young people's sexuality restrict their access to SRH services and information. By providing knowledge, skills, and resources to the many "gatekeepers" such as parents, grandparents, marriage registrar staff, religious leaders, and health service providers and shifting their opposition to the provision of SRH to adolescents (particularly unmarried young people), The project has created an immense impact to the social fabric in target communities. The project has been built on comprehensive SRH and

life skills education proven to delay sexual initiation [4] and combat the false assumption that sex education at a younger age leads to increased sexual activity. In many cases, particularly at young ages, parents and communities perpetuate early marriage. Engaging parents – as well as grandparents and the elderly, who have great influence on cultural practices in communities - foster an understanding of the negative impacts of early marriage and restricted SRH, thereby shifting social norms at the source. ESDO also has strengthened the often ineffective or dormant Community Protection Networks that has established a sustainable monitoring system at the community level to prevent early marriages and provide constructive guidance and referrals to adolescents. Of key importance, religious leaders were targeted to lead a cultural paradigm shift in early marriage and ASRH practices.

The Actions: ESDO has implemented successful initiatives that enable adolescents in Bangladesh to develop life skills to negotiate for SRH through the establishment of safe spaces and access to educational curriculum. Without a developed understanding of gender, communication and negotiation skills, conflict resolution, goal-setting, and community participation, adolescents–particularly girls, who face increased human rights violations such as child marriage and gender-based violence–are unable to realize their rights. Although parents often facilitate early marriage for their daughters, girls may support marrying early, given existing inequitable social norms, women's financial dependence on men, and the emphasis on marriage as the ultimate goal for women. ESDO has targeted these underlying issues by establishing safe spaces in existing community sites where adolescent girls and boys facilitated with a comprehensive curriculum on SRH, gender equality, and life skills. ESDO has delivered a gender- and rights-based life skills approach for adolescents that have built a more respectful environment for women and strengthened girls' capacity to make decisions about their personal health and futures. Though many norms are engrained, ESDO have worked successfully to strengthen adolescents' knowledge and agency and facilitate community transformation. With age-appropriate health information delivered by a trained facilitator through engaging methods–particularly technology, which is often a source of misinformation for adolescents .

The Networks: ESDO has the network, experience, and expertise to work effectively and efficiently with frontline providers to enhance provision and accountability for youth-friendly health services (YFHS), enabling adolescents to exercise their rights to SRH care. Availability and access to SRH services was restricted for unmarried girls and boys due to lack of trained professional staff, materials, and appropriate service facilities–and perhaps more importantly by the absence of confidential, nonjudgmental counseling by health service providers. Building on the GOB's commitments highlighted in its WHO-based National Standards for YFHS, The project has provided intense and structured support for stronger implementation at the field level where such services, care, and counseling were limited. This was basically hand in hand with supporting attitude and behavior change at the parent and community level, as well as encouraging adolescents to use health facilities to address a range of SRH needs and access counseling to learn about their bodies, unwanted pregnancy, closely spaced pregnancies, unsafe abortion, and HIV/AIDS. In such a circumstance, ESDO has shown successfully in the project, by targeting unsympathetic approaches of health staff and the lack of an adolescent- friendly environment, reversing providers judgmental attitudes, limited opening hours, long distances, and lack of confidentiality. Through building capacity of health staff, strengthening available information and materials (e.g., contraception for married adolescents) at Family Welfare Clinics, Community Clinics, pharmacies, and other private practices–and rebranding these service centers– the project has ensured that adolescents can safely and comfortably access the information and materials they need to manage their personal health. ESDO have the networks, credibility, and track record needed to work effectively at the local and national levels to prevent early marriage and improve support service provision for adolescents. Translating national ASRH policy commitment to local enforcement starts with ensuring dedicated resources, improving weak monitoring systems, and addressing the lack of inter-ministerial coordination. ESDO build on a proven bottom-up advocacy approach to encourage policy implementation at the national and district levels while simultaneously strengthening systems and procedures in community structures to prohibit the practice of early marriage as national legislation gradually trickles down.

The Approach:ESDO has approached to leverage **existing programming** and **strong government and community relationships** to deliver cost-effective, high-impact support for adolescents and their communities within the relatively short three-year time frame for behavior change. The project strategy works to improve adolescent health and well-being through interventions at the supply and demand sides of services in a supportive community environment;• **Supply of services**: Strengthening YFHS delivery at health service sites – Family Welfare Clinics (FWC), community clinics (CC), and pharmacies – through improved access to accurate information and materials, establishment of adolescent-friendly spaces in the sites, and access to confidential, non-judgmental counseling;• **Demand for services**: Delivering health information and life skills to unmarried adolescents and counseling on family planning (FP) and relationships for married adolescents to build their knowledge and agency to access health services, strategically linking with local health staff "champions" to introduce adolescents to the availability of improved YFHS in the community; **Enabling environment**: Engaging with key gatekeepers in the community to commit to delaying marriage and pregnancy and supporting adolescents' health and wellbeing.

ESDO has approached to build and empowering adolescent girls to realize their rights (including delaying marriage until age 18 or later) through capacity building at three levels; **Individual:** Targeting unmarried adolescent girls and boys in two age cohorts (10-14and 15-19), along with married adolescent girls (age 15-19) and their husbands through life skills building and referrals to SRH care and services; **Family/community** (gatekeepers): Targeting the families of adolescents and key community leaders to build a supportive environment for delaying marriage and promoting adolescents' access to SRH; **Institutional**: Strengthening existing health systems to deliver youth-friendly health care and services and build the capacity of local and district governments to strengthen commitment to preventing early marriage included improving perspectives of health workers and other support service personnel.

Based on the community scorecards, ESDO has worked with stakeholders to implement changes, such as establishing confidential spaces in pharmacies for consultations. Added to this, ESDO has also mobilized adolescents to advocate for changes with local government committees (e.g., the Community Clinic Committee). This community-led approach has ensured that YFHS improvements are community-led, community owned and sustainable.

Box 2: ESDO Life Skills Modules

1. Identity and goals , 2. Values, 3. Gender awareness, 4. Interpersonal relationships, 5. Families, 6. Communication and decision-making 7. Emotions, 8. Puberty and reproduction, 9. Sexual and reproductive health, 10. Understanding GBV, 11. Understanding child marriage, 12. Financial literacy, 13. Jobs and Working, 14. Rights, 15. Planning for the future.

Using existing channels in schools and communities, ESDO worked to reach unmarried adolescents (in separate platforms for 10-14 year-olds and 15-19 year-olds) and promote sustainable behavior change. The after school and community- based clubs held in gender-segregated safe spaces led by a community facilitator working in tandem with one or two youth volunteers. Motivation and interest have been key criteria for participation, but high-risk adolescents (those out of school and living without two parents) were targeted to ensure for reach the most at-risk adolescents.

The strategies: Engaging boys: ESDO has strategically engaged adolescent boys in target areas because: 1) boys are critical allies in the movement for gender equity and delayed marriage; and 2) boys in Bangladesh suffer from higher levels of school dropout, hazardous child labor, and migration –suggesting the need for targeted life skills programming and support for boys. These platforms have taken a gender-segregated approach to ensure that adolescents have a safe and comfortable environment to discuss sensitive issues. They also had incorporated mixed-gender activities to strengthen adolescent communication and relationship-building skills with the opposite gender. ICT/media/outreach: Life skills program has incorporated creative ICT and media approaches to ensure it is engaging, youth-friendly, and accessible. Recognizing the gap between adolescents' knowledge and actionable access of health services, the project had created demand for health services through proven youth-friendly engagement strategies, including- Interactive computer, Theater for Development (TFD),Guest speakers , Linkage with the Women and Girls Lead Global (WGLG) ,Community Protection Mechanisms, Counseling and referrals for married adolescents, Positive deviance couples, Volunteers for life skills clubs & Religious Leader Counseling.

Box -3 : Case Study 1: The rescue of Most. Jannatun Khatun from early marriage

Most. Jannatun Khatun, 17 years of age, has been reading in 10th Class in Kadirabad High School. It had been decided to give her marriage with Md. Sariful Islam who was a young man of Bamanpur. All the arrangement for the marriage has been completed. Most. Jannatun Khatun is a participant the project implemented in Pirganj Upazila. Most. Jannatun Khatun would not like to get married in the early age and she wants to continue her education. Her own mother is in favor of her daughter. As per the decision of her father she was about to give marriage and she became very disappointed. Both her mother and she knew that the project of ESDO has been working for the prevention of Child marriage, so to prevent the marriage they inform the situation to Ms. Rafikun Nahar, Community Facilitator of Tukuria Union of the Upazila. Ms. Rafikun Nahar and an another Community Facilitator of the Union, Mr. Masud Rana first inform the incident of early marriage to Mr. Md. Ataur Rahman Mandal, Chairman of Tukuria Union. But at the time the chairman was not in station so the Chairman had asked Mr. Ismile Hossain a Member of the respective Union to stop the marriage. But the UP Member was not so serious about the marriage and passing time loosely. In such a condition, Ms Rafikun Nahar and Mr. Masud made a phone call to Phone number 109.After this Mr. Kamal Kumar Ghosh, UNO of Pirganj Upazila requested Ms. Rebeka Yeasmin, Upazila Woman Affairs Officer (UWAO) of Pirganj Upazila to look after the marriage and to take action accordingly. Ms. Rebeka Yasmin collected information and reported to the UNO. Then the UNO asked Mr. Amir Hasan, UTC of the project at Pirganj to go to the respective area and to stop the marriage and to take necessary initiatives. Accordingly Mr. Ismile Hossain UP Member and Mr. Amir Hasan taken initiatives and the marriage had been postponed.

Case Study 2: Most Rina Begum finds a glimpse of light for the future

Most. Rina Begum is an adolescent girl of 16 years age. She was born in Kachabari a village of Kalupara Union in Pirganj Upazila under Rangpur District. After marriage she came to know that her husband has another wife. At the beginning she tried to accustom to the situation but failed. She is only an adolescent and was very disappointed with situation of second wife of her husband. The project of ESDO had started Life Skill Education in her village. She had become a participant of the Life Skill Education Session of 15 – 19 year adolescent girls. From the Life Skill education Session she can understand that early marriage is very harmful for life of girl and pregnancy before the age 20 is more harmful. So she wears an Implant to protect herself from pregnancy.Project initiatives were taken to find out some married adolescent girls to be a volunteer for Community Sales Agent. She expressed her willingness to be Community Sales Agent. Later on she was selected as a Community Sales Agent and received Training on Community Sales Agent. After the training she received Family Planning commodities (Joya Napkin, Fami pill, Raja Condom) and by selling these commodities she has started to earn decent amount of money. Most. Rina Begum is now determines that she will continue the business any way. Added to this Most. Tahira Begum, Community Facilitator of Kalupara Union of Badarganj Upazila of the project also helped her in many ways. She introduces Rina Begum with married women especially the adolescent married girls in different forums. Rina begum feels proud to present herself as a Community Sales Agent (CSA). Rina begum has prepared a list of married adolescent girls and keeps a close contact with them and uses to bring the adolescent girls in the Life Skill Session. She also uses to take the adolescent girls in the health facilities.

Why need to link with Clinical Social Work :ESDO operated A2H project is one of the most successful community based adolescent health focused program. Due to lack of professional clinical social work some limitations have observed. Clinical social work has a primary focus on the mental, emotional, and behavioral well-being of individuals, couples, families, and groups. It centers on a holistic approach to psychotherapy and the client's relationship to his or her environment. Clinical social work views the client's relationship with his or her environment as essential to treatment planning. Clinical social work is broadly based and addresses the needs of individuals, families, couples, and groups affected by life changes and challenges, including mental disorders and other behavioral disturbances. Clinical social workers seek to provide essential services in the environments, communities, and social systems that affect the lives of the people they serve. The Council on Social Work Education (CSWE) 2008 Educational Policy and Accreditation Standards (EPAS) defined *a set of practice behaviors for social workers to diminish behavioral health and health disparities and promote health equities*. If the community based health programs, like A2H will be followed the following knowledge and practice behavior, no doubt it will be created more innovative and sustainable problem solving solutions for the target audience:

Required Professional Knowledge according to the Council on Social Work Education (CSWE): (1) Understand multidimensional determinants of behavioral health disparities and their interacting nature. (2) Have a strong working knowledge of Code of Ethics supports health equity. (3) Understand the basic principles and concepts of equity and health. (4) understand the Universal Declaration of Human Rights and relevant policies. (5) Have a basic knowledge of ethical principles from related behavioral health disciplines. (6) Skills to conduct analysis and assessment of behavioral health disparities in the context of diverse identities drawing on race, ethnicity, culture, social economic status, gender, sexual orientation, immigration status and other socially constructed factors. (7) The structural and community factors of behavioral health disparities in the context of public health and prevention. (8) A critical consciousness drawing from the combination of self-knowledge and considerations of power and privilege. (9) Understand social dynamics such as discrimination, biases, institutional racism, and unequal access to resources, poverty, and differential environmental challenges. (10) Understand the vulnerability of marginalized populations to social determinants of health and behavioral health care delivery barriers. (11) Understand various advocacy strategies for promoting health equity and health justice. (12) Understand culturally grounded practice guidelines. (13) Understand that quality health and behavioral health care is a basic human right. (14) Understand that barriers related to access and services are rooted in power imbalances, social location, and social policies. (15) Understand how to develop and assess culturally-grounded approaches to behavioral health disparities. (16) Understand social and psychological change theories and the intersections between behavioral health and other service systems (e.g., criminal justice, child welfare, schools, etc.) (17) Understand the implications of fiscal, welfare, and health policies for practice approaches that address behavioral health inequalities. (18) Understand how organizational and community structures impede and impact health access and quality. (19) Anticipate and know how to respond to changing cultural, political, economic, and societal contexts (20) Have expertise in working relationships with community members, organizational partners, and cultural brokers. (21) Have expertise in working with multiple agency partners from different disciplines. (22) Have awareness of and conduct cultural adaptation when needed of evidence-informed interventions.

Impact of ESDO-A2H Project: (1) For seeking health service adolescents are going to health centers like Upazila Health Complex, Union Health & Family Welfare Center, and Community Clinics. (2) Service Providers giving priority for adolescent's health service & providing their service timely at health service center. (3) Adolescent Friendly Health Service Center established in the UH&FWC and Community Clinics. (4) Adolescent are having services from help line 109 (Protect Early Marriage), 16387 (SMC Helpline) and 09612600600 (Dosh Unisher More, Plan). (5) Religious leaders are verifying age before marriage to stop early marriage. (6) Religious leaders are awaring to stop early marriage through Khutba at Jumma prayers. (7 Most of adolescents in four working upazila's are aware on Sexual Reproductive Health and Rights. (8) Menstrual Hygiene products cell increased in working area. (9) Adolescents Forum actively working for different issues of adolescents. (10) Union Parishads are allocated additional budget for medicine, Menstrual Hygiene products, and FWC renovation from their yearly budget. (11) Superstation of parents reduces in the community which create enabling environment to access Adolescent Friendly Health service.

Conclusion: Out of the mentioned required skills, some of skills successfully addressed by Community Health Workers of ESDO but without proper guidance of Clinical Social Workers, it is really difficult to address some professional skills. Through the effective collaboration in between Academic institute of Professional Clinical Social Work (like ISWR) and Field based service providing agencies (like ESDO) is the effective pathway for sustainable community based health services. We are expecting that, Social workers stand to improve effective and just practice by increasing partnerships with community health programs for filling the gap in health and social disparities and this model provides possible effective solution to the problem of meeting the needs of underprivileged communities of Bangladesh.