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Enabling Adolescent-Friendly Health Services (AFHS) in a Rural Area in Bangladesh: An Implementation Research

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Published in October 2026

Background

Adolescents are a critical segment in Bangladesh, comprising about 36 million people, over one-fifth nationally [(1)]. Despite their importance, adolescents face challenges: poor sexual/reproductive knowledge, early marriage, malnutrition, mental health concerns, and underuse of services [(2-5)]. Social stigma, gender norms, and limited access to rural services exacerbate vulnerabilities [(5-7)]. Government of Bangladesh adopted 'National Adolescent Health Strategy 2017-2030' and introduced AFHS with facility-, school-, and community-based interventions [(1, 7)]. Building on programmatic experience, DGHS developed a holistic integrated package of health interventions [(1)]. In collaboration with DGHS, icddr,b conducted a pilot study to assess the implementation outcomes and effectiveness of this integrated model to inform future scale-up.

Objective

To assess the feasibility, acceptability, appropriateness, adoption, barriers, enablers and changes in adolescent health service utilisation of a multi-level AFHS model in rural Bangladesh.

Study Method

Study Sites



12 Intervention schools	Baliakandi Upazila Health Complex (UHC)

Quantitative Sample Selection

Participants

Adolescents (aged 10-19 years)	Teachers	Peer educators
Healthcare providers	Community gatekeepers	Facility, education and programme Managers

Sample Size

720 School-going adolescents	**384** Adolescents attending Baliakandi UHC	**24** Teachers
24 Peer educators	**8** Healthcare providers	**30** Community gatekeepers

In addition, secondary cohort data were analysed from **184** adolescent service users at baseline and 169 at endline.

Qualitative data were collected through:
- **4** Focus Group Discussions (FGDs)
- **10** Key Informant Interviews (KIIs)

Intervention Package

School

- Peer-led health education
- Health screening
- Referral to UHC
- Teacher supervision

Community

- Gatekeeper orientation
- Six union sessions
- Parent/ guardian engagement
- Local leader involvement

Facility

- Dedicated AFHS corner
- Training of healthcare providers
- Psychosocial counselling
- Referral care

Key Findings

Implementation outcomes across school, community, and facility levels

Feasibility

Schools, communities, and counselling spaces jointly supported the AFHS through educational integration, stakeholder engagement, privacy, comfort, and confidentiality.

> *"The school always gives them full support… I believe this is a part of education."*
>
> - *Head Teacher*

> *"It is very positive that you have engaged and informed the local elites."*
>
> - *Upazila Secondary Education Officer (USEO)*

> *"We have sufficient light, air, and a washroom here. Since our room is slightly off to the side, closing the door ensures confidentiality. The environment and color of the counseling room are smooth and comfortable in all aspects."*
>
> - *Psychosocial counsellor*

Acceptability

Student acceptability was exceptionally high across all activities, with over 89% satisfied or very satisfied (Figure 1).

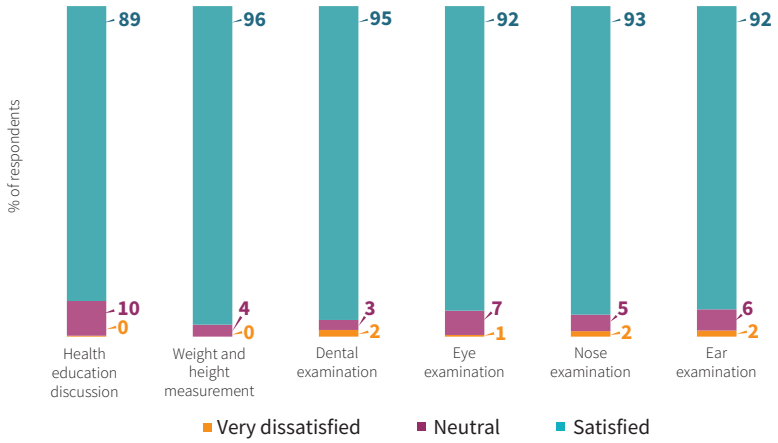


Figure 1: Student's acceptability of health education and health screening.

Appropriateness

Students perceived all school-based health activities as highly appropriate (98%–100%) (Figure 2).

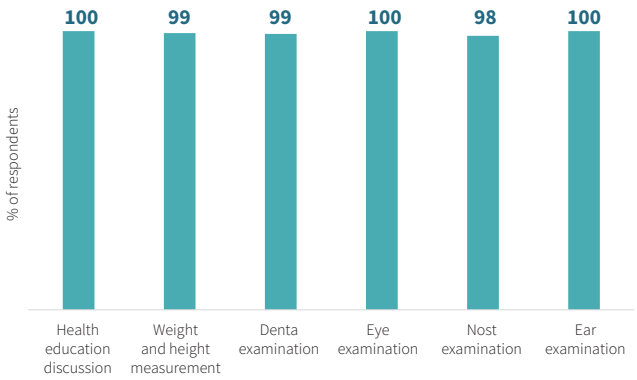


Figure 2: Students' perspective of appropriateness of health education and health screening.

Adoption

Activities were successfully integrated within regular school schedules without disrupting routine operations or encountering major implementation barriers.

> *"We are doing everything in between school times… we didn't face any major barrier during implementation."* - *Head Teacher*

Changes in service utilisation: UHC services among adolescents remained stable between baseline and endline (6.9% vs. 6.4%). The proportion of adolescents reporting that privacy was maintained during consultation increased markedly, from 11% at baseline to 43% at end line (Figure 3).

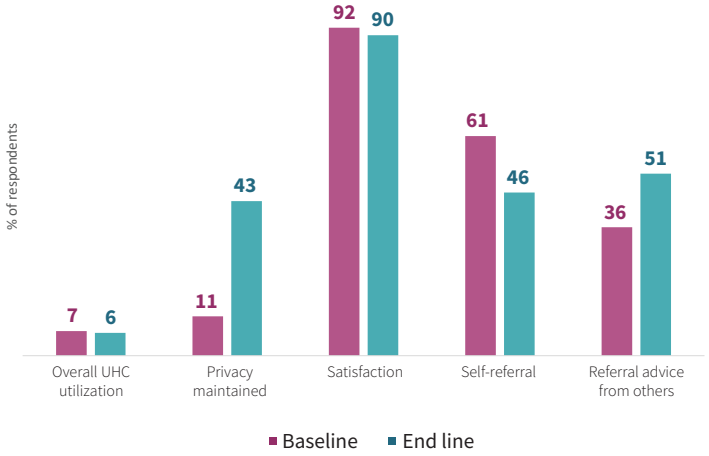


Figure 3: Changes in service utilisation.

Age and sex stratified utilisation

5% → 8%	Stable	8% → 4%
12-year-old girls: significant increase	14-year-old girls and boys	16-year-old boys: significant decrease

	Barriers	Enablers
School	• Cultural sensitivities around SRH • Embarrassment and teasing • Limited peer educator numbers • Academic workload • Lack of dedicated funds	• Strong peer-educator leadership • Teacher involvement; structured training • Peer-led delivery • Scheduling within routine school periods • Intersectoral coordination
Community	• Social stigma • Cultural norms • Misinformation • Suspicion around participation and incentives	• Trusted community gatekeepers • Parent engagement, especially mothers • Structured sessions • Community-clinic outreach • Informal referrals
Facility	• Insufficient human resources • Competing duties • Administrative delays • Documentation workload • Gender-related discomfort in counselling	• Dedicated adolescent-friendly space • Trained providers • Psychosocial counsellor • School/private-provider referral networks • Collaborative teamwork • Supportive leadership

> *When parents understand the purpose, they encourage their children. It makes a big difference in student participation."*
>
> - *Peer Educator*

> *The issue of manpower is our main challenge. It's very difficult to assign our senior staff permanently."*
>
> - *Healthcare Provider*

How this Study Added Value

The study generated real-world evidence that an integrated AFHS model can be implemented across schools, communities, and an Upazila Health Complex in rural Bangladesh.

It identified key implementation enablers and barriers, including leadership support, peer-led delivery, referral linkages, sociocultural stigma, human-resource constraints, and limited financing.

It also provided actionable evidence for programme refinement and scale-up by demonstrating improvements in privacy, referral pathways, and adolescent-responsive service delivery.

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This Study is funded by Global Affairs Canada (GAC) through the Advancing Sexual and Reproductive Health and Rights (AdSEARCH) by icddr,b project. Grant number: SGDE-EDRMS-#9926532, Purchase Order 7428855, Project P007358.

In partnership with Canada

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