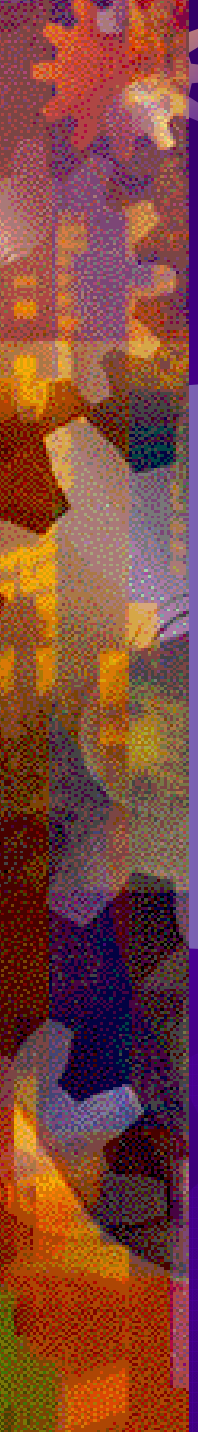

EXPERIENCES IN SCALING UP TWO MODELS OF SEXUAL & REPRODUCTIVE HEALTH SERVICE PROVISION TO ADOLESCENTS IN BANGLADESH:

THE CASE OF MARIE STOPES *CLINIC SOCIETY*

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1988: Marie Stopes Clinic Society (MSCS), affiliated with MSI, UK, was established with one modest clinic for providing FP services to urban women (Finance: UK, ODA, JFS)

Huge success

1990-92: Three (3) more clinics (Finance: EC)

Consolidation

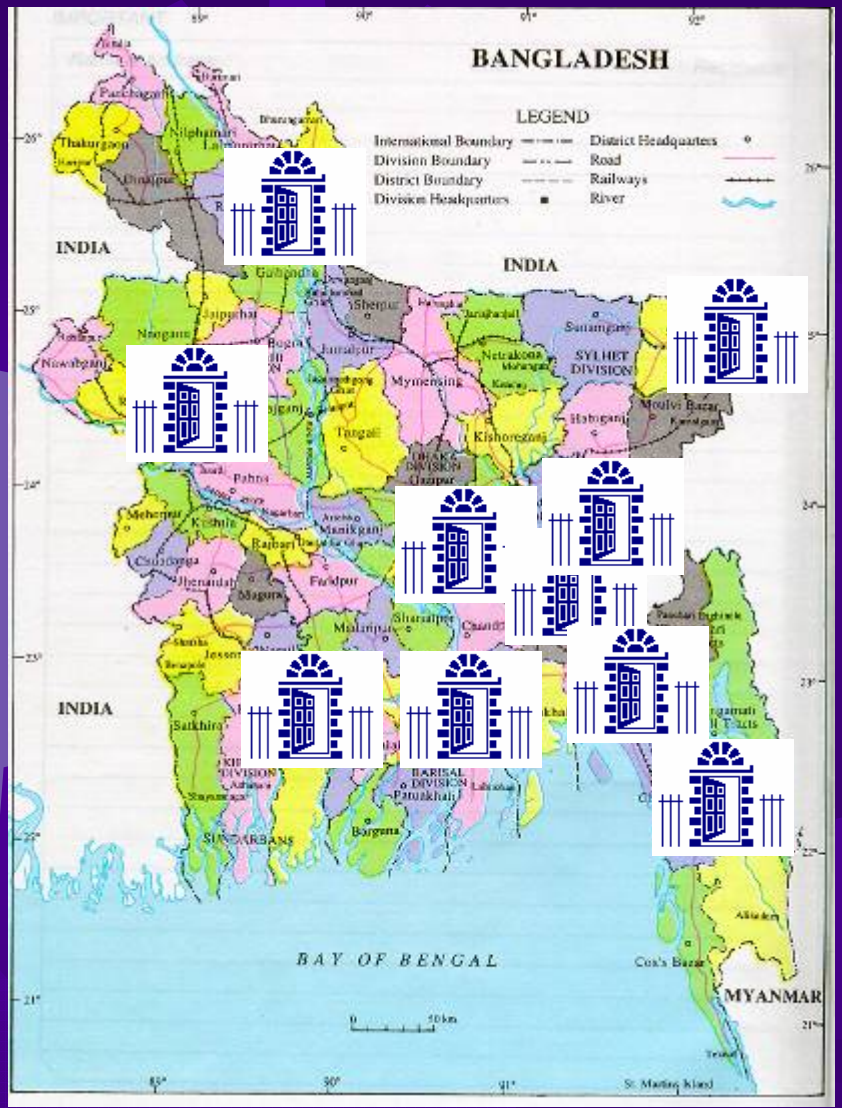
1995: Large gamut of SRH included within service context (Finance: Large Bilateral Fund from DFID)

Expansion of service coverage

1996: MSCS started working with vulnerable & marginalized groups

Targeting adolescents

2005: 25 clinics & 1600 satellites sessions per month in 15 districts



MSCS' Referral Clinics across Bangladesh

Adolescents – The Diverse Group

- A phase in which the individual is no longer a child but is not an adult; a time of opportunity and risk
- Experiences of adolescence vary by sex, marital status, class, region and cultural context

In Bangladesh

- Adolescents represent approximately one-fourth of the population
- They Lack information on sexuality, contraception and STIs including HIV/AIDS
- Have limited access to SRH services
- Available services unresponsive to ‘broader needs’ of adolescents
- Conditions worse for ‘disadvantaged’ & ‘marginalized’ adolescents
- MSCS started focusing on ‘these’ adolescents, devised two models in 1996 & 2002

Objectives

To Demonstrate

- How MSCS felt the need and decided to reach out to the adolescents
- How MSCS developed models of service delivery tailored to the special needs of the target group
- How the capacity of MSCS was used to build these models and ensure quality of care, management, scaling up and sustainability

Methodology

MSCS: Baseline surveys, workshop reports, publications, project documents, evaluation reports, MIS

Others: Related articles on program intervention for adolescents

Health Card Scheme Model

- Garment Factory- one of the booming industries in Bangladesh
- Employs >1.5 million cheap labor
- 70-80% are women workers
- 70% are adolescents, migrated from rural area
- Work form 8 am to 8 pm

- Extreme poor knowledge about SRH or about 'growing up'
- But need is high as they suffer from poor ventilation, sanitation, less fluid intake, poor diet and less mobility
- By the time they finish work, health service outlets are closed

MARIE STOPES *Clinic Society*

MSCS Approach- Health Card Scheme Model

- Partnership with Garment Factory Workers
- Worksite Intervention

Basic Criteria

- *Location*
- *Minimum number of workers: 300 per factory*
- *Payable to MSCS by Factory Mgt- Tk 15/worker/month & space/s for service*
- *MSCS' satellite team conducts clinical service & health education sessions in the factory premises*

MSCS' Health Card package includes…

- *General health check ups with selected drugs*
- *Pregnancy check-ups, TT immunization*
- *Gynecological problems, family planning*
- *STIs, RTIs with drugs*
- *Skin problems*
- *Age estimation certificates*
- *Health education (monthly session)*
- *Referral linkages with MSCS clinics with subsidized rates*

Slum-Based Model

- Urban slums in Bangladesh are inhabited by country's most poor and vulnerable people
- Adolescents living in slums are most at risk group, suffer from intergenerational poverty, a dire lack of education and employment opportunities
- SRH services and information almost non-existent
- *MSCS carried out series of PNAs & Brainstorming workshop with stakeholders to devise a model*
- ***The slum based model thus evolved and first piloted in 2002.***

Design of the Slum-based Model

- Existing infrastructure of Mini Clinics used
- Club-based model, peers recruited from the community.
- Program designed as per ‘needs’ of the adolescents

Needs…..

- *afternoon clinics without affecting school hours*
- *different look of clinical set ups, youth friendly ambience*
- *separate branding (other than MSCS), Moni-Mukta Ashor*
- *availability of young service providers*
- *provision for recreational and life skill development activities*

Features of the Club……

- Separate sessions for boys & girls
- 12 peers per club
- 3 days clinical sessions & 3 days health education, recreational, life skill
- Informed peers arrange community meetings with parents, elders, and influential people of the community
- Arrange slide shows and talks on SRH with other adolescents
- Learn singing, dancing,drama, painting, making soap, candles, embroidery, etc

Discussion

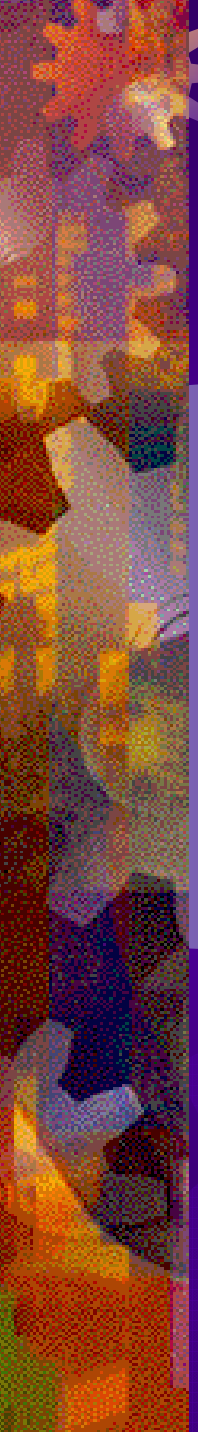
Program Design

Health Card Scheme:

- Worksite intervention
- Dependent of factory owners
- Peer strategy not worked
- Flexibility less
- Entry very difficult

Slum Based Model:

- Fixed and club-based, operates 6 days a week
- Peer strategy successful
- More flexible, could incorporate innovative services
- Relatively easy beginning

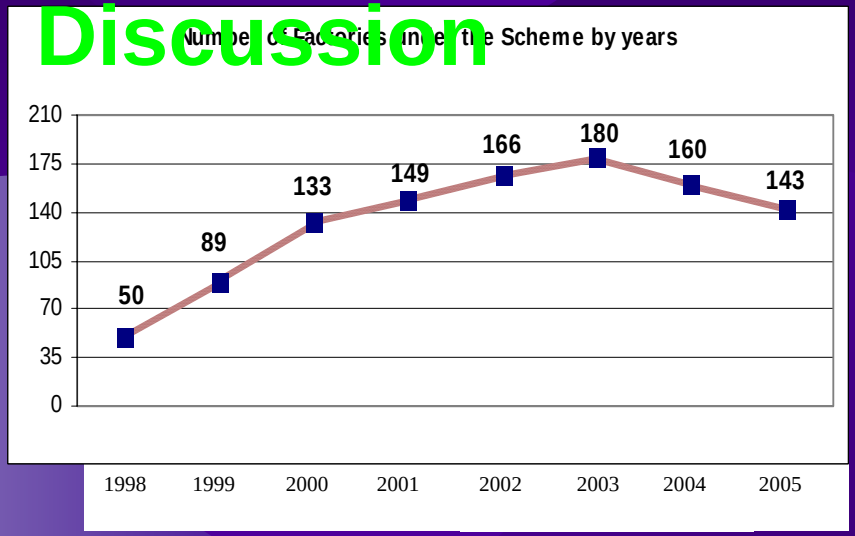


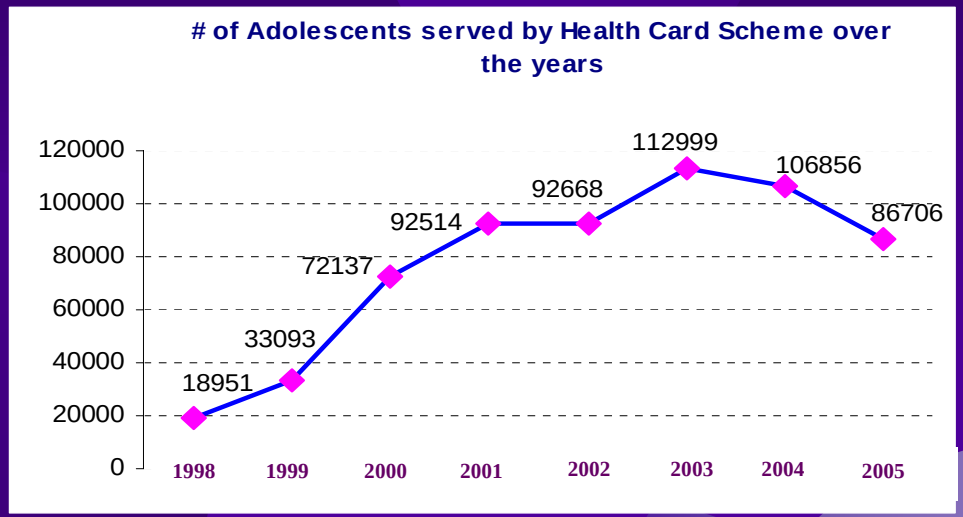
“If you come again to our house, I will beat you with the broom.” “I will break your leg.” “You have started preaching unacceptable information just after your birth.”- “You are over matured” “Who is going to marry these girls?” “You are spoiling the community by teaching vulgar words.”

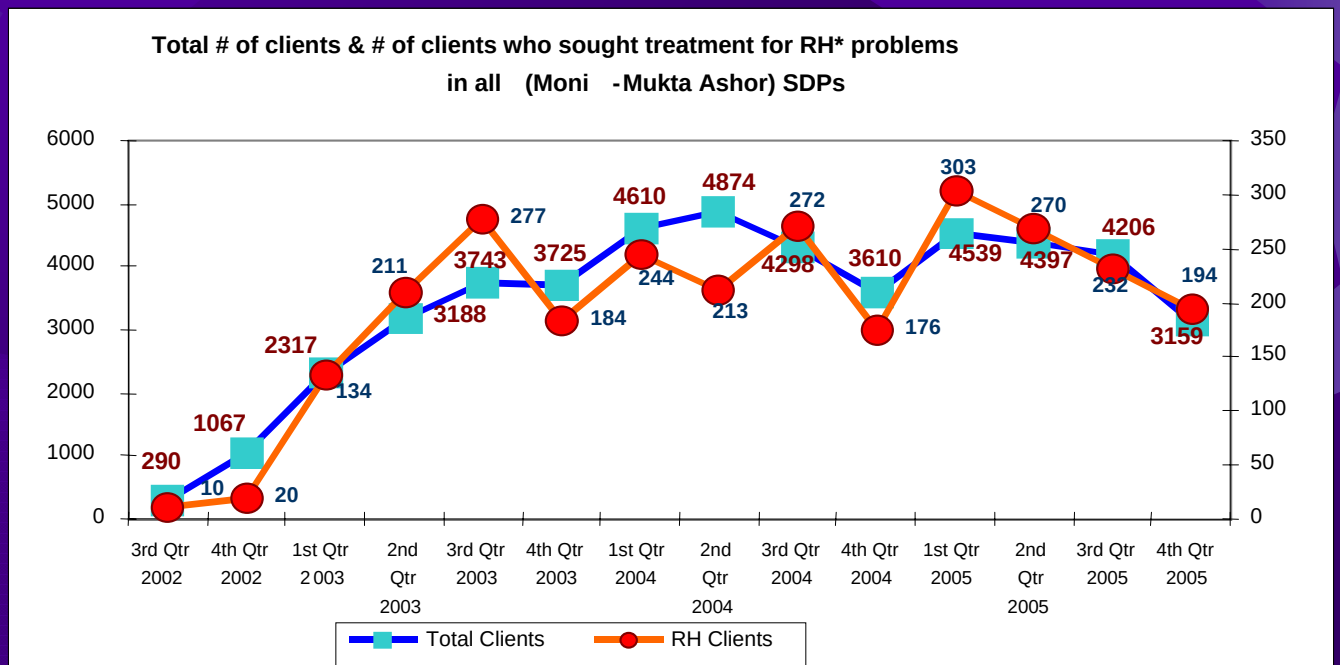
Service Utilization

Discussion

Discussion







Discussion

Health Education sessions

Slum Based Model

- Able to provide structured/tailored BCC/HE activities over prolonged time
- Has snowballing effect
- Could address social issues like early marriage, dowry, violence, alcoholism

Health Card Scheme Model

- Not able to provide BCC/HE activities for long time
- Related with buyers' concern
- No enduring change in behavior

Discussion

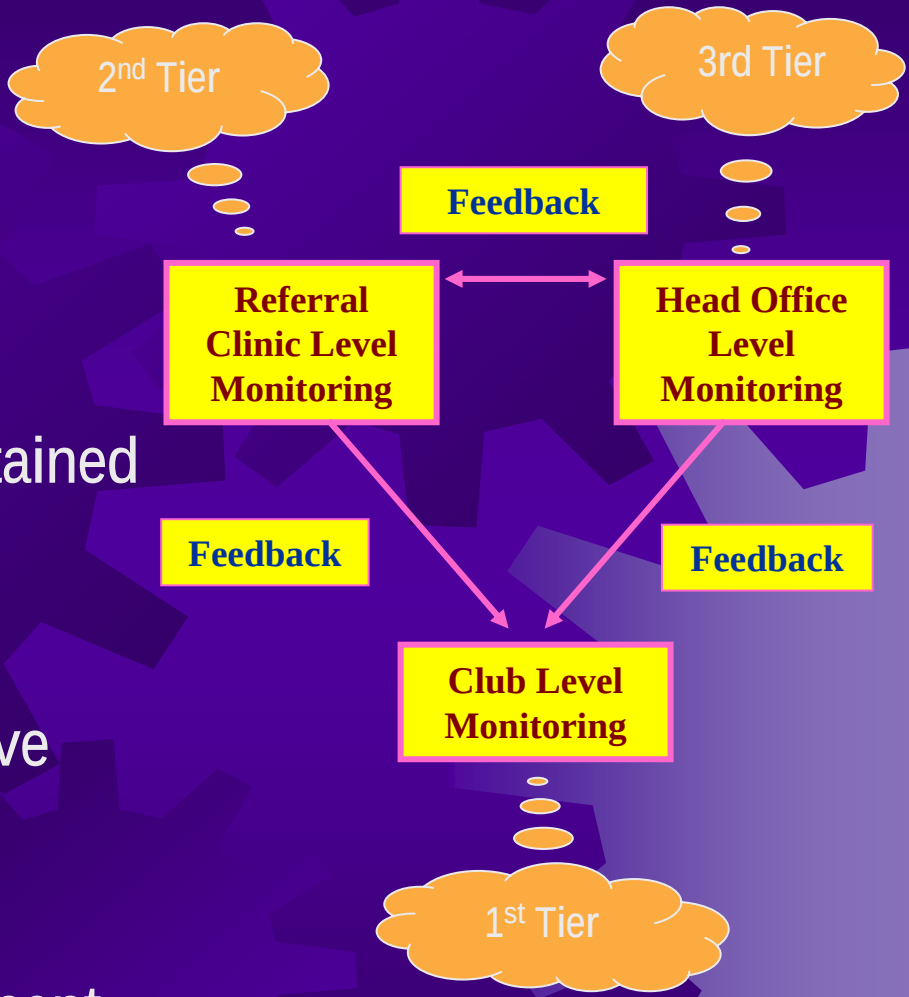
Ensuring Quality Monitoring & Evaluation

Slum Based Model

- Comparatively convenient & effective
- MSCS' 'Three tier' M/E can be applied
- 'Adolescent friendliness' can be maintained

Health Card Scheme Model

- Less convenient & not 'always' effective
- Dependency on factory owners
- Ad-hoc arrangements
- Client Friendly, but not always Adolescent Friendly



Discussion

Scaling Up & Sustainability

Health Card Scheme Model

- Scaled to 180 in 2003, came down to 143 in 2005 (4 districts including Fish Processing Factories)
- Cost recovery 81% (98% if overhead costs deducted)
- Highly sustainable model
- End of DFID support in 2004, able to run on its 'own'
- Sustainability largely dependent on International buying decisions

Slum Based Model

- Scaled up to 12 SDPs by 2003 (2 districts)
- Cost recovery varies from 5-10%
- Financially not at all sustainable
- Breathing on MSCS' cross-subsidization model since cessation of DFID funding in 2004

Conclusion

- **Both the Models efficient in reaching the adolescents**
- **One model not successful in other, as responses are different**
- **Sustained change in behavior depends on flexibility in program**
- **May be financially sustainable, but not always**
- **Need for 'third-party' financing**
- **MSCS could have stayed back, building more sustainable clinics for its usual client group, but …..**

MSCS was up to the challenge, to carry on,

as these **'informed' adolescents can act as agent of change**

Acknowledgements

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