Improving Adolescents' Reproductive Health Bangladesh

Introduction

In Bangladesh, adolescents comprise one-fourth of the population. This large group is at risk for a wide variety of reproductive health problems such as unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS, especially if reproductive health (RH) information and services are not available or used. In general, RH knowledge among adolescents is low. Most adolescents have no idea about the changes associated with puberty (e.g., menstruation or wet dreams) until they experience them. Their knowledge of symptoms, transmission, and prevention of STIs and HIV/AIDS is inadequate. In addition, adolescents generally do not go to the proper health care providers for their reproductive health problems.

Traditionally, early marriage prevented premarital sex. However, as the gap between age at menarche and age at marriage increases, adolescents are at risk from unprotected sex. Although social customs discourage premarital or extra-marital sexual relationships in Bangladesh, several studies have reported such relations. Unmarried but sexually active adolescents reported that they did not feel comfortable seeking family planning or STI services from nearby clinics and pharmacies and perceived providers to be judgmental and unfriendly (Bhuiya et al. 2000).[1]

[1] Bhuiya et al. 2000. "Reproductive Health Services for Adolescents: Recent Experiences from a Pilot Project in Bangladesh." Paper presented at the International Conference on Adolescent Reproductive Health: Evidence and Programme Implications for South Asia, Mumbai, 1-4 November 2000.

In Bangladesh, the strong family structure plays a major role in the lives of adolescents but fails to respond to adolescents' needs for reproductive health information. Although parents think that they should serve as role models for their adolescents, that role does not include providing information on sexuality and RH. The existing service delivery system does not cater to the needs of unmarried adolescents. Consequently, most adolescents lack information on their bodies, sexuality, contraception, STIs, and HIV/AIDS.

Adolescent reproductive health is a difficult programming area. Some program managers believe that current adolescent RH problems stem from a lack of RH knowledge and adolescent-friendly services, but they are not sure how to address these problems. Others feel that providing RH information and services to adolescents will make adolescents more sexually permissive and compound their problems.

This research update describes the baseline findings and implementation status of the Bangladesh Adolescent Reproductive Health project. This study is part of a multi-country operations research project (Improving Adolescent Reproductive Health) that investigates the effectiveness of interventions to improve adolescent RH knowledge and practices.

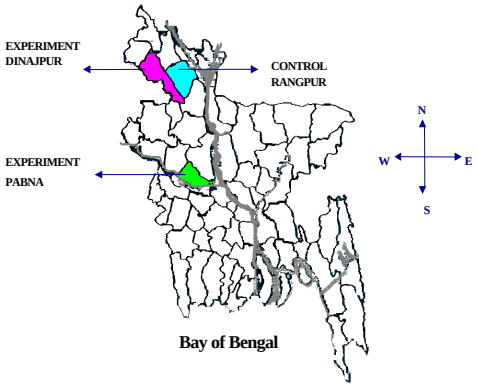
Background

The Urban Family Health Partnership (UFHP) and its three NGO partners are collaborating with the Population Council to implement the study. The proposed interventions include: (1) making the social environment conducive to change by sensitizing various stakeholders about the reproductive health information and service needs of adolescents; (2) educating both in-school and out-of-school adolescents about human physiology, reproduction and contraception; and (3) sensitizing the NGO clinic staff to adolescents' reproductive health needs, such as keeping separate clinic hours for adolescents and ensuring confidentiality.

The project is taking place in the northwestern part of Bangladesh (Figure 1). The two intervention sites and the control site are located in three different clusters (a cluster serves a population of nearly 500,000). The two intervention sites, Pabna and Dinajpur, are located 260 kilometers apart. The control site (Rangpur) is adjacent to an intervention site (Dinajpur), but they are 100 kilometers apart. The three sites are urban areas with similar socio-cultural characteristics. Approximately 12,000 households from each site were selected for the interventions.

Figure 1

Location of Project Sites



Findings from the Baseline Survey

- The enumeration survey identified a total of 42,760 households (27,670 in experimental sites). Of those identified, 27,282 households (17,573 in experimental areas) had at least one adolescent.

- A total of 2,971 adolescents aged 13-19 were interviewed; half of these were girls. Forty-seven percent of boys and 51 percent of girls were currently enrolled in schools. Approximately 22 percent of girls and 1 percent of boys were married. The married adolescents are excluded from this analysis.

- Findings from the baseline survey and focus group discussions showed that parents and religious and community leaders support the idea of including RH education in the school curriculum.

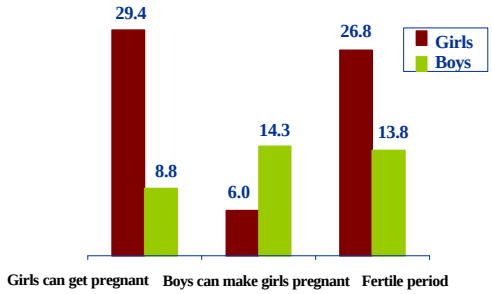
- Parents felt that it was very difficult for them to discuss RH issues with their children and that school would be a better place for RH education. However, they also said that RH education should be optional and should be taught when children were mature enough.

- Many schoolteachers felt that the RH curriculum might increase premarital sex. However, they agreed that increased awareness could help adolescents avoid STIs and social problems such as pregnancy before marriage.

- Adolescents' knowledge of places to obtain condoms or prenatal care services was very high. Their awareness of sources for other family planning services and protection against STIs was also quite good. Fewer than one in four knew when a woman's most fertile days occur during the menstrual cycle (Figure 2).

Figure 2

Percent of Adolescents Who Gave Correct Answers to RH Questions by Sex

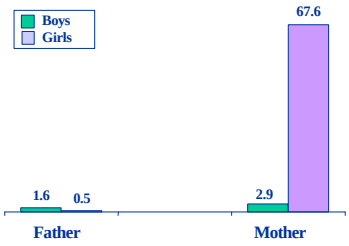


- The baseline survey of adolescents and parents shows no difference by sex (boys and girls) and age (adolescents and parents) with respect to ideal age at marriage for boys (25 years) and for girls (18 years).

- Adolescents were asked whether they discussed RH issues with their parents. Figure 3 shows that only 0.5 percent of girls and 1.6 percent of boys reported that they discussed RH with their fathers. More than two-thirds of the girls reported that they discussed RH issues with their mothers. The findings show that 1 percent of boys received information about ejaculation from their fathers, and 46 percent of girls received information about menstruation from their mothers.

Figure 3

Percentage of Adolescents Who Discussed RH Issues with Parents or Guardians



- Adolescents were asked whether they had received reproductive health information from other sources. Approximately 48 percent of girls and 58 percent of boys reported that they had received RH information from other sources. Table 1 shows that 96 percent of male adolescents and 45 percent of female adolescents received RH information from their friends. Also, 64 percent of female adolescents reported receiving information from relatives other than parents.

Table 1

Sources of RH Information for Adolescents

Source	Boys (%)	Girls (%)
Doctors	2.0	1.3
Books/Magazines	4.6	3.1
Relatives	6.3	63.8
Friends	96.4	45.2
TV	2.5	1.4
Total Number	843	553

- Out of 2,626 unmarried adolescents, 127 males and 3 females reported premarital sexual experience. The mean age at first sexual experience was 15 years. Fifty-seven adolescents reported that they had had sex in the last six months. The survey showed that only one-third of these 57 adolescents used a condom at first and last intercourse. Fifty-two males had sex with a commercial sex worker and did not use a condom. Fifteen male adolescents had experienced signs or symptoms of STIs, but only nine of them sought treatment (Table 2).
- Friends were the primary source of RH information for the 130 unmarried sexually active adolescents.

Table 2

Behaviors of Sexually Active Adolescents

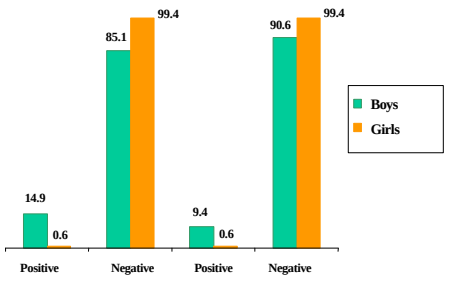
RH Behavior	Girls	Boys
Sexually Active	3	127 (8.7%)
Total Number	1164	1462
Had sex in the last six months	1	57 (44.9%)
Unconsensual sex	2	7 (5.5%)
Used a method at first intercourse	1	30 (23.6%)
Used a method at last intercourse	-	35 (27.6%)
Has experienced signs & symptoms of STIs in the past six months	1	15 (11.8%)
Sought treatment for STIs	-	9 (7.1%)
Total Number	3	127

- Over 90 percent of the adolescents reported that they had not visited health facilities in the last six months. Fifteen female and seven male adolescents had visited health facilities. Female adolescents were more likely to visit government facilities than private and NGO clinics, while male adolescents were more likely to visit private facilities.

- More than 85 percent of the adolescents believed that they would not be treated respectfully if they visited a health facility for FP services. Boys' and girls' perceptions varied slightly. Figure 4 shows that 15 percent of adolescent boys believed that they would be treated well if they visited a clinic for FP services, while only 0.6 percent of adolescent girls reported the same. The scenario was almost the same for pharmacy visits.

Figure 4

Adolescents' Perceptions of Providers' Attitudes Regarding Provision of FP Services to Them



Implementation of the Intervention

On the basis of the information collected, interventions have been introduced to make the existing services friendlier to adolescents. To create an enabling environment, project staff have conducted sensitization meetings with gatekeepers (parents, teachers, religious leaders, community leaders, health service providers, political leaders and government officials) to discuss adolescents' reproductive health needs and the availability of RH services. The gatekeepers also received behavior change communication materials such as leaflets and brochures.

A 20-hour RH curriculum, "*Alor Pothe Amra*," has been introduced to in-school and out-of-school adolescents. The curriculum includes information about personal hygiene, food and nutrition, environment and sanitation, changes in adolescence, child health and immunization, marriage and legal rights, gender roles, drug abuse, sexual relationships and sexual abuse, STIs including HIV/AIDS, the childbirth process, antenatal care, postnatal care, population growth, and family planning. The curriculum employs simple language, stories, case studies, and feedback mechanisms.

Out-of-School Adolescents: Sixteen young adults aged 21–28 were selected from the community as facilitators to conduct the RH sessions for out-of-school adolescents. The facilitators had at least 14 years of schooling. Facilitators received a five-day training course to educate them on adolescent RH issues, inform them about preventive and curative health services, and improve their facilitation skills. Out-of-school adolescent boys and girls aged 13–19 were identified and organized in groups (male and female) of approximately 12 to 15 adolescents in each group. Groups were formed according to age, sex, employment status, and marital status considerations in each group. The facilitators met once a week to share their experiences and resolve any problems. To date, more than 1,200 out-of-school adolescents have received RH education.

In-School Adolescents: Project staff identified seven secondary schools and provided the reproductive health course for classes eight and nine. Two teachers were selected from each school to teach these courses. They were trained for four days on adolescent reproductive health and facilitation skills. In most cases, science and social science teachers were identified for this activity. In general, the teachers were comfortable with the RH curriculum but had reservations about the promotion of condoms. The trained teachers prepared an implementation plan for the RH sessions and met monthly to share their experiences. In the first phase, 478 adolescents attended the RH course.

Service Providers: Health care providers have been trained to make facilities more adolescent-friendly. Adolescent-friendly services include reproductive health care services, treatment for common ailments and general adolescent health concerns, prevention and treatment of reproductive tract infections and STIs, family planning services, antenatal and postnatal care, treatment for anxiety and depression, supportive counseling, and appropriate referral. In addition, a confidential telephone hotline and post-box facilities have been established for adolescents who are not comfortable visiting a health care facility for services. Queries from the post-box facility are answered in the adolescents' column of a local newspaper.

Clinics have introduced additional convenient hours for adolescents only. Clinic staffs were trained to treat adolescent clients with care and respect. To maintain privacy and confidentiality, physicians perform all services (history taking, physical examination, treatment, and counseling).

Adolescents who participate in RH sessions receive free services from the UFHP clinic. UFHP-supported NGOs have introduced pre-paid health cards costing Taka 20 for adolescents. With these cards adolescents can consult doctors at a UFHP clinic for one year without any additional consultation fees.

Conclusion

The project seeks to improve the reproductive health status of adolescents through well-designed interventions. The interventions seem appropriate to address reported needs and knowledge gaps. All stakeholders appear to recognize the need to provide information about sexual and reproductive health to adolescents, but there is disagreement as to how much information should be given, particularly when adolescents want to know more about the physical and emotional changes they are experiencing. The findings from this project will help policymakers and program managers to design and implement strategies for improving the RH status of adolescents in Bangladesh.

This Research Update *was prepared by Ubaidur Rob and Ismat Bhuiya.* For more information, contact: *Population Council, House CES (B) 21, Road 118, Gulshan, Dhaka 1212, Bangladesh. Tel: 882-1227, 882-6657; Fax: 882-3127, E-mail:frontiers@popcouncil.bangla.net* .

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Research Update

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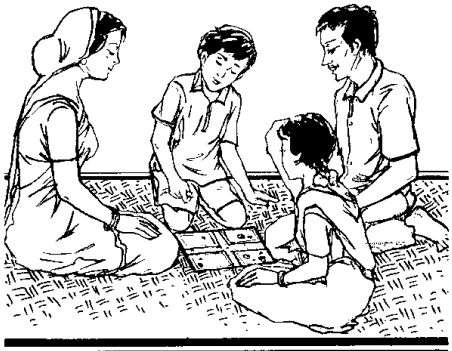

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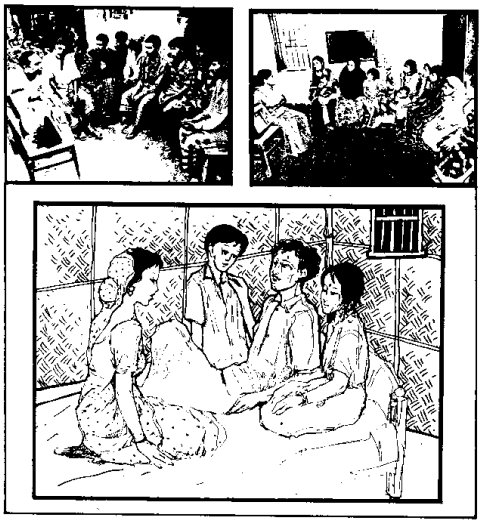

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