ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN BANGLADESH

Status, Issues, Policies, and Programs

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ABBREVIATIONS

AFLE	Adolescent Family Life Education
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
BRAC	Bangladesh Rural Advancement Committee
BRDB	Bangladesh Rural Development Board
CBD	Community-based distribution
CEDPA	Centre for Development and Population Activities
DHS	Demographic and Health Survey
ESP	Essential Services Package
FP	Family planning
FPAB	Family Planning Association of Bangladesh
HIV	Human immuno-deficiency virus
HKI	Helen Keller International
HPSP	Health and Population Sector Program
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
MMR	Maternal mortality rate
MOHFW	Ministry of Health and Family Welfare
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
NNP	National Nutrition Project
PKSF	Pally Karma Sahayak Foundation
RTI	Reproductive tract infection
RTI	Research Triangle Institute
STI	Sexually transmitted infection
TFR	Total fertility rate
TT	Tetanus toxoid
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence against women
WHO	World Health Organization

1 INTRODUCTION

This paper on adolescent reproductive health (ARH) status in Bangladesh is part of a series of assessments in 13 countries in Asia and Near East.[1] The purpose of this assessment is to highlight the reproductive health status in each country, within the context of the lives of adolescent boys and girls. The paper begins with social issues—the issues that need to be addressed to meet the reproductive health needs of adolescents. It also outlines specific ARH issues, legal and policy issues related to ARH, current in-country programs on ARH, its operational barriers, and concludes with recommendations to improve the situation in Bangladesh.

Bangladesh's adolescent population (ages 15–24) was estimated at about 28 million in 2000. Due to the effect of population momentum—through which populations can continue to grow even as the rate of growth is declining (since ever more people are added to the base population each year)—and other effects, this age group will contribute significantly to the incremental population size of Bangladesh during the next 20 years,[2] increasing by 21 percent to reach 35 million by 2020 (Figure 1). With a total population of about 130 million,[3] adolescents comprise 22 percent of the total population. Educational attainment is increasing for both boys and girls, and there has been a significant increase in the percent of boys and girls obtaining a secondary or higher education. This increased from 10.5 percent to 54.9 percent for boys, and 5.5 percent to 47.1 percent for girls between 1994 and 2000 (Figure 2). Births to adolescents will increase from 2.2 million in 2000 to 2.9 million 2020 (Figure 3). Unmet need for contraceptives has improved slightly over the past six years. It is now about 20 percent for girls ages 15–19, and slightly lower at 18.1 percent for girls ages 20–24 (Figure 4).

The main causes of mortality in young mothers are toxemia, abortion, and obstructed labor (caused by immaturity of the birth canal). In addition to its associated health consequences, early childbearing has an adverse effect on a young mother's socioeconomic status. It cuts short her education, limits her ability to earn income for the family, and can lead to marital difficulties.[4]

Adolescents appear to be poorly informed with regard to their own sexuality, physical well-being, health, and bodies. Whatever knowledge they have, moreover, is incomplete and confused. Low rates of educational attainment, limited sex education activities, and inhibited attitudes toward sex contribute to this ignorance.[5]

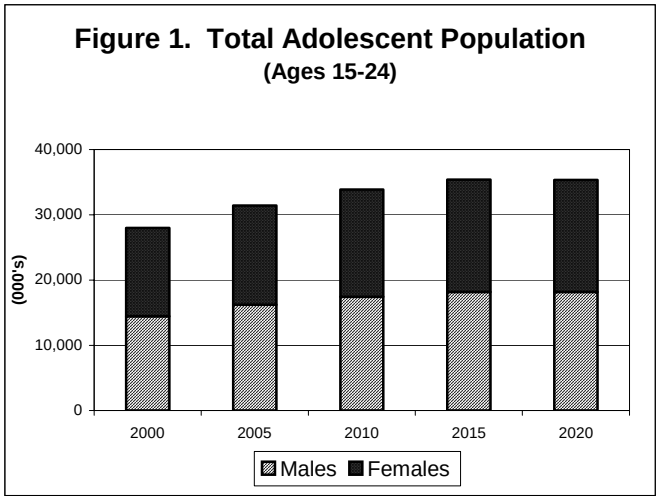
The reproductive health needs of young women are quite different from those of young men, principally because of their young age at marriage. According to WHO, worldwide, girls younger than 18 are up to five times more likely to die in childbirth than are women in their twenties.[6]

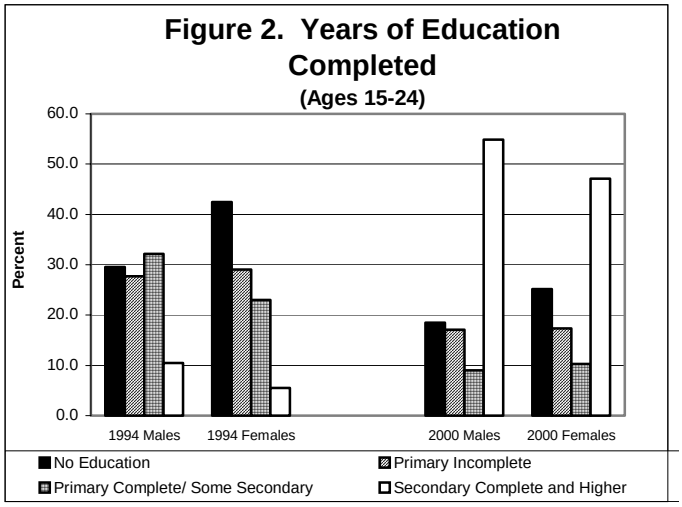
The government of Bangladesh has thus identified adolescent health and education both as a priority and a challenge and to face the challenge, has incorporated this issue in the current Health and Population Sector Program (HPSP, 1998–2003). There are expectations that with the introduction of the Essential Services Package (ESP) across Bangladesh through the HPSP, there will be an overall increase in the

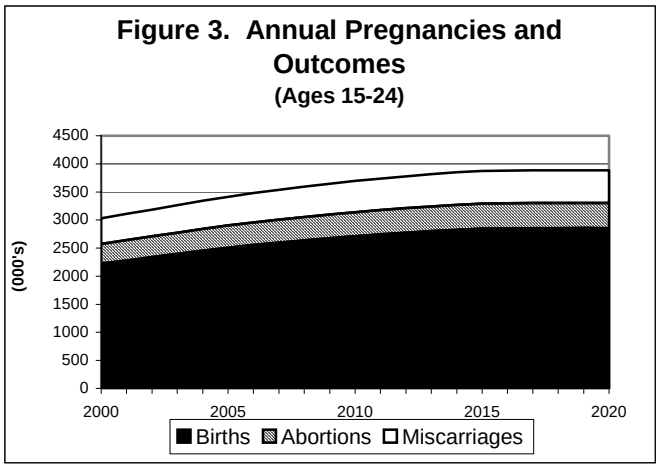
[1] The countries include Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Vietnam, and Yemen.
[2] Barkat, 2000.
[3] Bangladesh Bureau of Statistics, 2002.
[4] MOHFW, 1998a.
[5] Jejeebhoy, 1996.
[6] WHO, 1998.

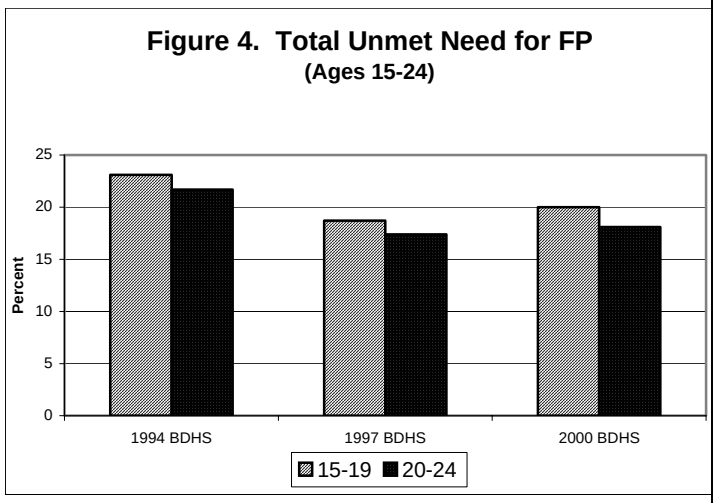
quantity and quality of information and services available for adolescents through a network of clinics at various levels: community, upazila (subdistrict), and district. However, studies conducted by the different agencies concluded that the potential for improvements directly associated with HPSP service delivery are unlikely to make significant contributions to achieving ARH results during the HPSP period (1998–2003) without additional efforts from other agencies.[7]

ARH indicators in Bangladesh









Note: See Appendix 1 for the data for Figures 1 through 4

[7] Annual Progress Review of HPSP, 2000 and 2001.

2 SOCIAL CONTEXT OF ARH

Addressing the social context of ARH involves setting priorities among certain issues. In Bangladesh, the issues needing immediate attention, particularly for female adolescents, are gender discrimination, education, employment, marriage and dowry, and nutrition.

Gender discrimination

Gender discrimination in the form of discrimination against women has been identified as one of the prime ARH issues in Bangladesh. This form of discrimination starts at birth and continues until death. The discrimination exists in the spheres of education, employment, marriage, dowry, and even violence.

Gender-based violence (including threats of these acts, such as coercion or arbitrary deprivations of liberty) that results in or is likely to result in physical, sexual, or psychological harm or suffering to women are all pronounced in both public and private life in Bangladesh. Thus, violence against women is defined as and encompasses, but is not limited to, physical, sexual, and psychological violence occurring within the family and community. This includes battering; sexual abuse of female children; dowry-related violence; marital rape; traditional, non-spousal, harmful violence to women; violence related to exploitation; sexual harassment and intimidation at work, in educational institutions, and elsewhere; trafficking of women; forced prostitution; and violence perpetrated or condoned by the state.

According to the UNFPA State of the World's Women Population Report, 47 percent of the women in Bangladesh testify to having ever been physically assaulted by a male partner. This report, and the fact that Bangladesh would thus rank second in a list of 12 countries with a high rate of violence against women (VAW), caused a great deal of media attention. A recent study revealed rank ordering of different types of VAW, with verbal abuse being the most prevalent and alarming one; the second most widely occurring violence is battery, while dowry-related violence is third.[8] Marital rape is also quite prevalent.[9]

The *physical* consequences of violence against women include homicide, serious injuries, unwanted pregnancy, sexually transmitted infections (STIs) and HIV/AIDS, and disease vulnerability. Violence may also be responsible for a sizeable but unrecognized share of maternal mortality, especially among young, unwed, pregnant women.

The *psychological* consequences of gender-based violence include suicide and mental health problems. For women who are beaten or sexually assaulted, the emotional and physical strain can lead to suicide. These deaths are dramatic testimony to the paucity of options for women to escape violent relationships. Many such women are severely depressed or anxious, while others display symptoms of post-traumatic stress disorder. In Matlab Thana, homicide and suicide, which are often catalyzed by the stigma of rape, pregnancy outside marriage, beatings or dowry problems, accounted for 6 percent of 1,139 maternal deaths between 1976 and 1986.[10]

Gender-based violence also retards socioeconomic development due to its effect on women's participation in development projects. To avoid violence, adolescent women learn to restrict their behavior to a level that may be acceptable to their parents, husbands, and partners.

[8] Barkat and Ahmed, 2001.
[9] Barkat and Ahmed, 2001.
[10] MOHFW, 1998a.

Education

Education is called the prime mover of civilization and human development. Although equal opportunity of education of men and women is delineated as a fundamental state policy of Bangladesh, the educational status for adolescents is truncated, particularly for girls. The state of female adolescent education in Bangladesh can best be summarized as follows:[11]

- Only 23 percent of 15–19 years old women have had seven or more years of schooling (however, young women in Bangladesh today are more than three times as likely to achieve this level of education than previous generations).
- Only 49 girls are enrolled for every 100 boys enrolled in secondary school.
- Only 5 percent of women ages 18–19 have had 10 or more years of education.
- If a young woman has fewer than seven years of schooling, she is twice as likely to be married by the age of 18.

The gender gap in enrollment in primary as well as secondary levels of education has been dropping quickly due to the concerted effort of the government of Bangladesh; it is implementing a secondary education stipend program for girls.

Employment

Employment opportunity across all service sectors is one of the greatest concerns in Bangladesh, though conditions are improving. Gender and age discrimination in wage work is highly pronounced in Bangladesh. Although the garment sector had looked promising for women (1.5 million women work in garments), only 24 percent of all manufacturing workers across all industries are women. The major manufacturing industries in which women are concentrated are the food and beverage, textiles, garments, leather, tea, wood, and fabricated metal products. Nearly 46 percent of employees for agricultural activities (agriculture, fisheries, and poultry) are women. Women's participation in construction activities is increasing.[12]

Marriage

Early marriage is customary for female adolescents in Bangladesh. Almost all of these marriages are arranged by their parents.[13] Although the average age at first marriage is 18 years for females and 27 years for males, rural females tend to marry even earlier. Approximately 75 percent of the girls are married before the age of 16, and only 5 percent are married after 18 years, which is the legal age of marriage for females in Bangladesh.[14] According to the 1991 census, about one-half of the females in the 15–19 year-old age group are married compared with only 5 percent of males in this age group. By age 24, approximately 87 percent of the females are married compared with 31 percent of the males.[15]

Dowry

Dowry is the practice of the wife's family giving money to the husband's family to complete a marriage. It is widespread among all social classes—especially among rural people with lower educational levels. The choice of a wife is too often determined by the husband's need for money. Obtaining dowry money

[11] MOHFW, 1998a.
[12] MOHFW, 1998a.
[13] MOHFW, 1998a.
[14] MOHFW, 1998a.
[15] Bangladesh Bureau of Statistics, 1992.

is often the priority for the husband's family, with little regard for the girl who will become the wife. Once married, her labor is exploited and her body is used for her husband's sexual pleasure. When she becomes pregnant, however, she can expect little support, prenatal care, or extra nutrition. Violence is often associated with the failure to pay a promised dowry.

The use of dowry, while perceived of badly by many and by which female adolescents (particularly those in rural areas) are made to suffer greatly, is still extremely common. It continues in spite of the fact that adolescents (both male and female) and their parents are opposed to the process. It results in social degradation of females and in many cases, results in divorce. Dowry is also a major cause of violence against women and suicide or homicide. All adolescents and gatekeepers participating in a focus group discussion in Bangladesh agreed that dowry was a social evil and a serious threat to the life of female adolescents.[16] The adolescents taking part in the focus group discussion noted that it was a bad and immoral practice that brings a negative effect to their married life.[17] While the government of Bangladesh has promulgated an anti-dowry act for the prevention of the use of dowry, the custom remains as there is still a lack of awareness and empowerment of females. Dowry remains at the core of marriage negotiations and a frequent bone of contention.

Nutritional status

The nutritional status of adolescents in Bangladesh is deplorable. A large number of adolescent girls suffer from malnutrition. The prevalence of malnutrition is found to be markedly higher among female children compared with male children. Short maternal height has been found to account for a sizeable number of low birthweight babies (2.5 kilograms) who are subsequently more susceptible to infections and death in infancy. Those who survive grow up as undernourished adults, giving rise to an inter-generational cycle of undernourishment. Additionally, small pelvis size may cause obstructed labor due to cephalo-pelvic disproportion. The consequences for women range from ill health (from chronic morbidity due to infections of the reproductive system and conditions such as vesico-vaginal fistulae) to death during and after child birth.[18]

Over one-half of adolescent girls are stunted and more than one-third of adolescent girls in rural areas are wasted. Adolescent girls suffer from iron, iodine, and vitamin A deficiencies. Forty-three percent of adolescent girls suffer from iron-deficiency anemia.

Knowledge of nutrition among adolescents is poor and they are generally unaware of the need to consume healthy quantities of foods such as fish, meat, eggs, milk, vegetables, and fruits during pregnancy and lactation. One study in Bangladesh sought to evaluate adolescents' understanding about food required for pregnant and lactating mothers: 40 percent mentioned fish, 27.5 percent mentioned meat, 38 percent mentioned eggs, and 34.7 percent mentioned milk. Similar proportions of adolescents mentioned food requirements like meat, fish, eggs, and milk for themselves.[19]

The study described above also asked the female guardians (mothers of adolescents) their opinions on whether adolescent girls or boys need to increase their food intake. Of these guardians, 43.1 percent indicated that boys require more food than girls, 19.4 percent indicated that female adolescents need more food, and 37 percent mentioned that the requirement was the same for male and female adolescents. Perceived reasons for boys needing more food included boys doing more physical activity/manual labor (52.5 percent); boys becoming earning members of the family (32.1 percent); the need for good health/strength for boys (6.2 percent); and the need for boys to develop good brains/studies (3.4 percent).

[16] Sona et al., 2001.
[17] Sona et al., 2001.
[18] Bangladesh National Nutrition Survey, 1998.
[19] Akhter et al., 1999.

The reasons for giving more food to girls included that the girls will go to their husbands' houses and thus will stay with parents for less time (50 percent); the wear and tear on the body due to pregnancy, childbirth, and blood loss during menstruation (2.3 percent); more physical activity/housework (8.2 percent); the need for good health/nutrition (8.2 percent); and having more health problems than men (4.1 percent).

The findings of the *Bangladesh National Nutrition Survey, 1998* (relating to adolescents ages 10–17) reveal high levels of both stunting and thinness among adolescent girls. Over one-half of girls ages 10–12 (54 percent) and 13–17 (56 percent) were found to be stunted, with generally higher rates in rural compared with urban areas. A slightly lower proportion of adolescent boys were stunted: 47 and 50 percent for the two age groups, respectively.[20]

The *Bangladesh National Nutrition Survey, 1998* showed comparative data on energy intake of male and female adolescents. Girls consume fewer calories than boys. They consume 8 percent fewer at ages 10–12, 18 percent fewer at ages 13–15, and 28 percent fewer at ages 16–19. In terms of meeting energy requirements, boys ages 13–17 consume just enough calories to meet their needs but girls in the same age group have a 4 percent calorie consumption shortage. In the 10–12 year-old age group there is a shortage among both boys and girls. Deficiencies in calorie intake are greater among urban compared with rural girls.[21] An anemia survey conducted by Helen Keller International (HKI), Bangladesh in rural areas reported that 43 percent of the 200 adolescent girls ages 11–16 who were studied were anemic.[22]

An indication of the prevalence of iodine deficiency disorders (IDD) among male and female adolescents was obtained from a cross-sectional survey in Upazilla of Bangladesh. The survey reported that 3 percent of adolescents had a visible goiter (i.e., an enlarged thyroid). A visible goiter is nearly twice as common among adolescent girls compared with adolescent boys.[23]

A study of approximately 1,000 male and female adolescents (ages 10–17) in a rural area of Bangladesh found that 1.6 percent were suffering from night blindness and 2.1 percent were suffering from physical signs of vitamin A deficiency. A sub-sample of 189 adolescent girls from a large-scale vitamin A survey reported that sub-clinical vitamin A deficiency was found among 12 percent of the adolescent girls ages 12–16.[24]

The community nutrition services under the National Nutrition Project (NNP, Ministry of Health) will be provided to nutritionally vulnerable groups: children younger than two, adolescent girls, and pregnant and lactating women. In addition to other core activities, adolescent forums will be formed.

Adolescents in slum areas of Dhaka

In Bangladesh, a large number of adolescent and young women migrate from rural areas to participate in wage labor. Most of them live in city slum areas and work in the garment industry. Most of the garment industry is in Dhaka. Nearly 2 million people work in the garment sector. An estimated 80 percent of all total garment workers are female, of whom 50 percent are adolescent girls. No serious studies have been conducted so far on the situation of garment workers. However, a nutritional study of adolescent working girls in a city garment factory revealed low energy and nutrient intake. Another health-affecting factor is

[20] Bangladesh National Nutrition Survey, 1998.
[21] Sona et al., 2001.
[22] HKI/Bangladesh, IPHN, NIO, and INFS, 1999.
[23] Bangladesh Bureau of Statistics, 1996.
[24] HKI/Bangladesh, IPHN, NIO, and INFS, 1999.

that they work for 12 hours, on average. Their reproductive health is at risk due to poor dietary intake, among other reasons.[25]

[25] Karim and Ahmed, 1995.

3 ARH ISSUES

Ensuring that ARH is addressed in a comprehensive manner will require an understanding of the complete picture of adolescent health and the various aspects that need be addressed. These are discussed below.

Government response and responsiveness

The government of Bangladesh recognizes ARH as "unsatisfactory," both in terms of program efforts and actual performance. A focus on adolescent health is new in the Health and Population Sector Strategy of Bangladesh but is nevertheless high on the agenda.[26]

The deplorable situation of ARH with regard to all its dimensions (including the increasing absolute size of the population and practical problems in addressing the issue) prompted the government to conclude that "in the field of population and health sector development, which forms the basis for human development, the most significant and critical challenges are: the population program itself and education, maternal health, adolescent health, and program sustainability."[27] It is officially recognized that the "lack of effective health programs for reaching out to young people was one of the major missing links in the past."[28] The current HPSP (1998–2003) has been designed keeping the above stated needs of adolescent health in mind.

Awareness

Adolescents and youth in Bangladesh are particularly vulnerable to health risks, especially in the area of reproductive health. This is due to their lack of access to information and services and societal pressure to perform as adults notwithstanding the physical, mental, and emotional changes they are undergoing. The current information and services that are available are not specific to adolescents, and the quality of such information and services is often poor or inappropriate for this age group.

A recent evaluation study of a Family Planning Association of Bangladesh (FPAB) program to reach youth was conducted in 12 of 71 project sites.[29] The results indicated that a substantial proportion of adolescents and youth are not knowledgeable about the following: the underlying cause/mechanism of menstruation, the consequences of unprotected sexual acts, gonorrhoea, syphilis, how a person is infected with HIV/AIDS, menstrual regulation, and the availability of treatment facilities for STIs.[30] Premarital sex was reported by approximately 7 percent of the adolescents in the study (both unmarried and married) and 21 percent of the unmarried youth. Over 50 percent of unmarried adolescent and youth did not use a condom during their first premarital intercourse. A large proportion of the married adolescents were

[26] MOHFW, 2000.
[27] MOHFW, 1999.
[28] WHO, 1998.
[29] The 12 project sites selected represent 12 districts whereby FPAB implements its youth program in 30 districts. A total of four non-project sites were selected by taking one from each greater division. In selecting these non-project sites, care was taken to select those areas that are not exposed to youth programs, either by FPAB or other NGOs. The survey samples included 1,600 adolescents (1,320 unmarried, 280 married), 480 unmarried youth, 480 parents, 80 community leaders, and 35 FPAB personnel. The major sample category—the adolescents—were divided equally between males and females. In addition, a total of 16 focus group discussions for the adolescents and the community leaders were conducted. Barkat et al., 2000.
[30] Barkat et al., 2000.

unaware of emergency obstetric care. Most young people and parents did not report support for polygamy or dowry.[31] In addition, a sizeable proportion of young people reported a lack of awareness of the causes of night-blindness.

Nevertheless, it is encouraging that most of the parents and community leaders do not support marriage of girls younger than 18 years. Most of them think that adolescents should be counseled for family planning and be informed about preventing STIs and HIV/AIDS. They also think that negotiation skills need to be imparted to young people to avoid unexpected sexual advances. Most adolescents, parents, and community leaders in the study consider information on sexual reproductive health as a right for adolescents and young people.[32]

Management of menstruation

The maintenance of hygiene during menstruation is a vital aspect of ARH. Although almost 70 percent of the adolescent girls in the FPAB study were aware of the need for maintaining some cleanliness during the menstrual period, these girls noted that they came to understand only after two to three years of the onset of menstruation that a clean pad or cloth is important.[33] Most girls (80 percent) in the Bangladesh Rural Advancement Committee (BRAC) study used pieces of old rags *(nekra)* as pads during menstruation, while others did not use anything. Sixty percent of the adolescent girls used rags that were wet or had not been dried in a hygienic fashion.[34] Ninety-nine percent of the girls in the urban slum study associated menstruation with being unclean or impure.[35]

The consequences of not maintaining hygiene during menstruation (e.g., becoming sick, itching, or ulceration of genitals) were least known among the female adolescents, especially those who were unmarried. Mothers, sister-in-laws, and friends are the sources of information about menstruation for most of them.[36]

Early pregnancy

Like early marriage, early pregnancy is common among female adolescents in Bangladesh. Pregnancy and motherhood often occur before adolescents are fully developed physically, which exposes them to particularly acute health risks during pregnancy and childbirth. Available information suggests that about 30 percent of adolescent Bangladeshi females are already mothers and another 6 percent are pregnant with first child. The adolescent fertility rate is one of the highest in the world with 147 births per 1,000 women younger than 20—a rate five times higher than in Sri Lanka.[37] Available information on adolescent nutrition indicates that about one-half of adolescent girls in Bangladesh are also under-nourished.[38] Preference for sons and the low status of women in Bangladeshi society affects girl adolescents' nutrition, education, and access to health care.[39] The extra nutritional demands of pregnancy come at the heels of the adolescent growth spurt—a period that requires additional nutritional input itself. Any shortfall in nutrition can result in the further depletion of the already malnourished adolescent. As a consequence, pregnancy at an early age, before the adolescent is physically fully developed, can result in

[31] Barkat et al., 2000.
[32] HKI/Bangladesh, IPHN, NIO, and INFS, 1999.
[33] HKI/Bangladesh, IPHN, NIO, and INFS, 1999.
[34] Ali et al, 1996.
[35] Ahmed, 1991.
[36] Barkat et al., 2000.
[37] MOHFW, 1999.
[38] Jejeebhoy, 1996.
[39] Akhter et al., 1996.

severe damage to the reproductive tract, elevated risks of maternal mortality, pregnancy complications, perinatal and neonatal mortality, and low birthweight. Younger mothers had a higher incidence of low birthweight and premature births after controlling for parity, height, weight, educational level, financial assets, and utilization of prenatal care, all of which were lower among adolescent mothers.[40]

Unwanted pregnancy

Unwanted pregnancy and unintended fertility among adolescents are due to various factors. One study conducted among teenage couples and newlyweds reveals that younger, married women are clearly much less likely to have ever been contacted by a family planning field worker or to have been contacted within the previous six months. This may, on the one hand, be a result of the fact that the current system does not provide incentives or encouragement for fieldworkers to visit the homes of young married women and newlyweds. On the other hand, fieldworkers may assume that a need for family planning services does not exist among the young and newlywed couples. However, according to the 2000 Bangladesh DHS, 20 percent of adolescent women ages 15–19 and 18 percent of adolescent women ages 20–24 have an unmet need. Although fieldworker contact was found to have a significant positive effect on current contraceptive use, over 30 percent of the married teenage women surveyed were never contacted by a family planning worker.[41] Thus, innovative and multi-dimensional program efforts need to be designed and implemented for the adolescent population.

Septic abortion

Septic abortion is one of the leading causes of death among those who want to end a pregnancy that is unplanned and, in many cases, is a consequence of a sexual union outside of marriage or within a marriage that has yet to be recognized by family members. In some cases, the pregnancy happens accidentally as a result of sexual violence. Whatever the circumstances, these adolescents usually choose the path of clandestine abortion either self-induced or induced by untrained individuals, which often results in sepsis of the uterus and birth canal. In Bangladesh, 14 percent of all obstetric deaths are due to abortion complications.[42] The health consequences of abortion are particularly acute for adolescents. Unmarried adolescents are considerably more likely than older women to delay seeking abortion services and hence undergo second trimester abortions.[43]

STIs and HIV/AIDS

The risk of contacting STIs including HIV/AIDS is a major public health concern for adolescents. Since the sexual habits of unmarried girls and boys of this age group are changing rapidly, knowledge of STIs is crucial.

A comprehensive study conducted among adolescents reported that only 13 to 14 percent of them were aware of syphilis and gonorrhea. About one-half of the adolescents could not correctly identify a single STI symptom and more than one-half of the adolescents could not correctly identify a mode of STI transmission.[44] Although social customs usually discourage premarital or extra-marital sexual relationships, the scant evidence from small-scale, in-depth qualitative studies indicate that such relationships are more frequent than commonly believed. These groups are especially vulnerable to

[40] Miller, 1998.
[41] Islam et al., 1998.
[42] Government of Bangladesh and UNICEF, 2000.
[43] MOHFW, 1998a.
[44] Barkat et al., 2000.

unwanted pregnancy and disease, including STIs and HIV infection, and the stigma and discrimination associated with either condition.

Maternal and child health

In Bangladesh, about one-third of adolescent women are already mothers and another 5 percent are pregnant with their first child. The proportion of teenage women who have begun childbearing increases rapidly with age, from 14 percent at age 15 to 58 percent at age 19. Adolescent women residing in rural areas are more likely than those in urban areas to have begun childbearing (37 percent versus 25 percent). Those with no education are far more likely to have begun childbearing compared with those with some secondary education.[45]

Adolescent mothers are more likely than women in their 20s to suffer pregnancy-related complications and to die from childbirth. The overall (national) maternal mortality rate (MMR) is 4.5 per 1,000 live births, but the adolescent MMR is 5.8 per 1,000 live births.[46] The results of Chen's study in Matlab showed that girls ages 10–14 had an MMR nearly five times higher than that of women ages 20–24.[47]

Mortality rates for children of all ages—neonatal, post-neonatal, infant, child, and under-five mortality rates—are higher when children are born to younger mothers. The infant mortality rate for children of mothers who are younger than 20 is 106, whereas it is 79 for those with mothers who are 20–29 years old.[48]

A recent study revealed that about one-fifth of adolescents did not receive any tetanus toxoid (TT) during their last pregnancy. The mother's blood pressure was not taken in four out of five births, nor was urine taken and tested during pregnancy. Antenatal care coverage was only 25 percent.[49,50,51,52]

In addition, Vitamin A deficiency among adolescent females is associated with increased illness, reduced work capacity, and lower health status during pregnancy. It also affects the nutritional value of a mother's breast-milk.

Given the above factors, there are a number of arenas that need to be addressed in order to adequately influence the health-seeking behaviors of adolescents and to promote a stronger operational commitment from all levels of government and national and international development agencies so that they might recognize and meet the specific needs and priorities for adolescents' health and rights.

[45] MOHFW, 1998a.
[46] Bangladesh Bureau of Statistics, 2002.
[47] Chen et al., 1974.
[48] NIPORT, 1999–2000.
[49] Barkat and Ahmed, 2001.
[50] Bangladesh Bureau of Statistics, 1992.
[51] Sona et al., 2001.
[52] Barkat et al., 2000.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

Legal issues are of major consequence with regard to ARH. These issues are explored below.

Legal barriers and laws

The Constitution of Bangladesh guarantees equal rights for men and women irrespective of caste, creed, and color. All citizens are entitled to equal protection under the law. There exist, however, very limited laws, regulations, or ordinances that are specifically designed to protect adolescents (particularly female adolescents) from exploitation and violence. The current laws, rules, regulations, and ordinances, while inadequate in terms of both the protection and promotion of rights as well as in terms of enforcement, include the following:

- The Dowry Prohibition Act of 1980 made the taking and giving of dowry an offence punishable by fine and imprisonment.
- The Cruelty of Women Act (Deterrent Punishment Act of 1983) provides punishment by death or life imprisonment for the kidnapping or abduction of women for unlawful purposes, trafficking women, or causing death or attempting to cause death or grievous injuries to wives for dowry.
- The Child Marriage Restraint Act (1984 Amendment Ordinance) raised the age of marriage from 16 to 18 for women and from 18 to 20 for men.
- The Muslim Family Ordinance, 1961 (Amended in 1985) regulates certain aspects of divorce, polygamy, and inheritance.
- The Penal Code (Second Amendment Ordinance) provides capital punishment for causing grievous injuries or acid throwing. Recently, the government declared a death sentence for acid throwing.
- The Family Court Ordinance, 1985 deals with causes of marriage, divorce, and the maintenance, guardianship, and custody of children.
- The Correctional Home for Juvenile Offenders (Ordinance 1974) provides rehabilitation programs for adolescent offenders under the supervision of magistrate.
- The Penal Code 1860 (Sections 312–314) permits abortions only for saving the life of expectant mothers.
- The Anti-terrorism Ordinance of 1992 provides punishment for all types of terrorism including teasing through making mockery of women or abducting children and women.

While laws, rules, regulations, and ordinances for adolescents exist, implementation of the existing ones are very poor or faulty, causing a breach in security for adolescents.

ARH policies and initiatives

In a January 2001 circular, the Director General of the Directorate of Family Planning declared the following adolescent health problems as priorities and accordingly, for the first time, suggested relevant information and service delivery for adolescents at various tiers of the public health system:

- Nutritional deficiency, particularly iron and iodine deficiencies.
- Early and unwanted pregnancy.
- Problems related to menstruation.
- Maternal mortality related to early and risky pregnancy.

- Problems due to complications of unsafe abortion.
- Reproductive tract infections (RTIs)/ STIs related to unprotected sexual activities.
- Addiction to narcotic drugs.
- Accidents, violence, and sexual abuse.
- Uncommon infectious diseases.
- Lack of information, education, and services. [53]

The steps already taken by the ESP of the Directorate of Family Planning are as follows:

- Production, printing, and distribution of health education materials for adolescents to increase awareness on adolescent health and ARH.
- Production, printing, and distribution of information, education, and communication (IEC) materials for guardians, teachers, and social leaders to increase awareness on adolescent health and ARH.
- Provision of health education for adolescents on nutrition and adolescent health.
- Distribution of iron and folic acid tablets to combat malnutrition and anemia.
- Provision of Tablet Hyocine-N-Butyl Bromide/Ibuprofen through the Union Health and Family Welfare Center for the treatment of dysmenorrhea.
- Provision of consultation and treatment for various ARH problems.
- Provision of consultation and treatment for RTI-related problems of adolescents.
- Provision of counseling for adolescents' physical and mental health problems, and provision for the diagnosis and treatment of these problems in the case of any abnormality.

The above mentioned services, including referral, are now being provided under ESP (Reproductive Health) at different tiers of the health system, which includes community clinic, union health and family welfare center, Upazilla health complex, and maternal and child welfare center levels.

[53] Directorate of Family Planning, 2001.

5 ARH PROGRAMS

A number of reproductive health programs exist in Bangladesh through the public sector, NGOs, and sectors outside of health. The results are positive as well as under-realized. These are discussed below.

The public sector

The government of Bangladesh has identified adolescent health and education both as a priority and a challenge and to face the challenge, it has incorporated this issue in the HPSP. It is expected that with the introduction of the ESP across Bangladesh through the HPSP there will be an overall increase in the quantity and quality of information and services available through a network of clinics at various levels: community, thana (upazilla), and district. However, studies conducted by different agencies concluded that the potential for improvements directly associated with services delivered through HPSP are unlikely to make significant contributions to achieving results in the area of ARH during the HPSP period (1998–2003) without additional efforts from other agencies.

The current HPSP aims to provide a one-stop provisioning of health services to the needy population. Under the ESP, it is proposed that community clinics be set up in a phased manner with the involvement of the community. It is proposed that these clinics would provide services to adolescents (among others). An important component of the ESP package is reproductive health, which includes adolescent care. The government is committed to developing community clinics and designating health, including reproductive health, services for adolescents in an adolescent-friendly environment. Nevertheless, in spite of all the initial efforts, ARH is a sensitive social issue, and it will be difficult for the government to implement all it wants effectively and efficiently.

The NGO sector

Despite all of the difficulties, Bangladesh is forging ahead to implement improvements in ARH and provides an excellent example of governmental–nongovernmental collaboration. NGOs have established a path for other programming by developing various innovative programs for ARH.

NGOs, which provide a grassroot-level presence, are trying hard to address the issue of ARH. A survey conducted by the Population Council reports that 188 NGOs work with adolescents in some capacity.[54] Most of the 89 NGOs responding to the Population Council mail survey reported that they are involved in the following activities: vocational training for skill development, micro-credit, leadership training, adolescent family life education (AFLE), sex education, reproductive health services, personnel hygiene education, and legal assistance in cases of violence and abuse against women. A few of the NGOs have developed their own IEC materials on adolescent sexual and reproductive health and reproductive health rights. The following are some of the NGOs that have fairly visible ARH components in their programs: FPAB, ACTION AID, Bangladesh Population Health Consortium (BPHC), BRAC, Bangladesh Women's Health Coalition (BWHC), Concerned Women for Family Development (CWFP), Family Development Services and Research (FDSR), Gonoshasthya Kendra (GK), Nari Maitree, Pathfinder International, Population and Services Training Center (PSTC), Urban Family Health Partnership (UFHP), Shoishab Bangladesh, Thengamara Mohila Sabuj Sangha (TMSS), Unity Through Population Services (UTPS), VHSS, USC, Nari Uddog, and World Vision.

[54] Hossain et al., 1998.

According to the most recent (September 2000) "Directory of Reproductive Health NGOs" by the South-South Center, Bangladesh, there are 72 national and international NGOs that provide elements of adolescent health in their programs.[55] The names of these organizations are provided in Appendix 2.

Although most of the organizations working in adolescent health are engaged in community-based distribution (CBD) activities, a few of them provide specialized functions. Overall, the NGOs have done a good job in designing adolescent family life education curricula (see text box below), which have been tested and implemented among both in-school and out-of-school adolescents.

Adolescent Family Life Education (AFLE) Curriculum[56]

Adolescence: The period of adolescence; physical and mental changes during adolescence of boys and girls; importance of the adolescent period.

Reproduction and menstruation: Reproductive health; male and female reproductive organs; process of ovulation and menstruation; process of fertilization; menstrual hygiene; nutrition during menstruation.

Marriage and pregnancy: Age of marriage; age of child bearing; danger of early marriage; normal pregnancy; antenatal, natal, and postnatal care; signs of complications during pregnancy and delivery.

STIs and HIV/AIDS: Common RTIs (including a discussion of personal hygiene); common STIs; signs and symptoms of STIs; risks and transmission; complications of STIs; prevention of STIs.

Family planning and birth control: Why family planning is needed; types of contraceptives; advantages and disadvantages of contraceptives; how to use contraceptives; condoms and their advantages.

Smoking/substance abuse: Smoking-related illness; reasons for substance abuse; signs and symptoms of substance abuse; health hazards resulting from substance abuse.

Gender issues: Inequality between males and females; respect between sexes; roles of males and females in reproduction.

It is difficult to measure the impact of the ARH information and/or service delivery NGOs in Bangladesh working at the community level. They have been responsible in great part for increasing opportunities for women through non-formal and formal education through delivery of reproductive health services (often on the doorstep) and credit programs for women. According to their stated objectives, the majority of NGOs targeted the poor and disadvantaged.

Beyond the health sector

"Equal opportunity for all" has been delineated as a fundamental state policy of Bangladesh. The gender gap in enrollment in primary level education has been reduced and the secondary school enrollment gap is being reduced quickly due to a concerted effort to implement the secondary school stipend program for girls. Working side-by-side, the government and NGOs have introduced the non-formal education program. Since education is the most important means of empowering the future generation, the

[55] Chen et al., 1974.
[56] Barkat et al., 1999.

government has allocated considerable resources for this sector. ARH has been incorporated in the curriculum of secondary school education and includes population, reproductive health, and family life elements.[57]

A good number of ministries and NGOs are implementing various programs to ensure gender equity and equality, and empowerment of women for the welfare of the adolescents. Among the 31 ministries and agencies identified in this process is the Ministry of Women and Child Affairs, which acts as the leader at national and international levels and coordinates primary women in development activities.

In addition, a number of government organizations and NGOs have recently developed packages for women entrepreneurship in traditional and non-traditional sectors. The government's micro-credit programs (BRDB, PKSF etc.), the Grameen Bank, BRAC, and Swanirvor are noteworthy among those advocating and providing support for the self-reliance of women.[58] To further improve the situation, multisectoral coordination among various sectors (e.g., education, labor, law, justice, youth, and social affairs) is underway.

[57] Nath and Barkat, 2000.
[58] MOHFW, 2000.

6 OPERATIONAL BARRIERS TO ARH

The unmet need of adolescents for reproductive health information and services is huge and diverse both in terms of quality as well as quantity. Due to various reasons—lack of ARH policy, proper programmatic effort, and inadequate understanding of the gravity of the issues on ARH—it has not previously been possible to meet the growing unmet need for information and services among adolescents. This shortcoming has been clearly recognized in an official document that states, "Lack of effective health program for reaching out to young people was one of the major missing links in the past."[59]

The operational barriers that need to be overcome to establish an ideal scenario can be clustered into three broad groups: physical access barriers, psychological and social barriers, and quality barriers. The relative strength of these barriers has been recognized by the relevant health sector officials, who in turn have suggested various measures to address the situation.[60]

The *physical access barriers* include inadequate reproductive health service points; inadequate clinical services for RTIs/STIs and HIV/AIDS; absence of peer group approach in the service point; lack of clinical instruments for screening RTI/STI and HIV/AIDS; and so forth.

The *psychological and social barriers* play pivotal roles that include shyness of adolescents to discuss the reproductive health issues; keeping reproductive health problems secret; traditional values; norms and myths; ignorance about sexuality; and parents/guardians and elderly people (who act as gatekeepers) who are uninformed about ARH needs.

The *quality barriers* include the service environment, which does not ensure privacy and confidentiality of adolescent service seekers; lack of professional staff or lack of professionalism among professional staff; inadequate supervision and monitoring of ARH services; and relatively high service charges.

[59] MOHFW, 1998b.
[60] Bangladesh Bureau of Statistics, 2002.

7 RECOMMENDATIONS

Considering the high unmet need for ARH information and services, the deplorable situation of the adolescents, and the socio-cultural conservatism that prevails in the country, the following recommendations are made:

1. Gatekeepers, formal and informal community leaders, and religious leaders at all levels need to be motivated and trained on ARH and gender issues.

2. Additional support should be provided to catalyze increased knowledge and attitudinal and behavioral change among service providers with regard to ARH.

3. Service providers at all levels should be trained on ARH.

4. An effective referral system should be developed.

5. Special training should be conducted for adolescent boys and girls at community clinics, satellite clinics, family welfare centers, and Upazilla health complexes.

6. An adolescent family life education curriculum needs to be developed.

7. Increased networking between all relevant government organizations and NGOs working with adolescents should be encouraged to ensure the proper implementation of projects.

8. Female doctors need to be deployed for the provision ARH services to adolescent girls.

9. Counseling services for the male and female adolescents need to be arranged.

10. Adolescent clubs need to be formed to advocate for improved ARH information and services.

11. Behavior change communication and IEC materials need to be developed and distributed in collaboration with multisectoral agencies.

12. Close relationships between the government and NGOs working on adolescent health should be maintained.

13. Hard-to-reach, out-of-school adolescents should be encouraged to form groups through which formal and informal leaders provide information and guidance.

14. The government and NGOs should help provide vocational training on various trades and provide loans for income-generation activities for adolescents.

15. The Ministry of Health and Youth Directorate could assist in conducting training to peer educators and partner NGOs.

16. Innovative strategies should be developed and implemented to deal with culturally sensitive ARH issues that require winning the confidence and desensitization of cultural gatekeepers (e.g., mothers and sisters-in-laws, parents, grandparents, village and community leaders, council chiefs, and religious/opinion leaders).

17. The feasibility of linkages with existing activities for an integrated approach to service delivery and adolescents' involvement in service planning and evaluation should be examined.

18. Both the government's and NGOs' experiences in ARH project implementation (e.g., networking and partnership-building, formation of advisory or management committees involving adolescents, and best practices) should be studied and replicated.

To meet the challenges of ARH needs and to achieve success, there is a need to draw upon the lessons learned by others. Based on the available information about documented best practices and the testing of new approaches, the following lessons will be important to ongoing, successful programming:

1. Addressing the special needs of adolescents does not require starting with a separate project or intervention targeting adolescents.

2. Comprehensive, multiple-intervention approaches can meet the needs of many target groups.

3. Basic human rights—clients' rights and reproductive rights—are a compelling rationale for offering reproductive health education and services to adolescents.

4. Data can be very persuasive in motivating parents and the community to support ARH initiatives.

5. Adolescents and service providers demand integrated reproductive health interventions.

6. Integrated reproductive health services that include STI prevention and screening can attract adolescents.

7. Health centers can be reconfigured to attract adolescents seeking information, counseling, and services.

8. Offering reproductive health information and services in non-clinical settings such as youth clubs/centers can also attract adolescents who may otherwise avoid health facilities.

9. Programs require support, advice, and assistance in addressing community resistance and opposition to ARH interventions.

10. In most settings, peer education is a culturally and politically feasible approach to reaching men, women, and in- and out-of school adolescents with information and services.

11. Adolescents can be effective agents for eradication of harmful "traditional" practices.

12. The sensitivity surrounding reproductive health services for adolescents is not an insurmountable barrier to demonstrating their feasibility.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (15–24) (000's)	2000	2005	2010	2015	2020
Males	14,457	16,215	17,444	18,209	18,185
Females	13,543	15,212	16,422	17,192	17,165

2. Level of Education (%)	1994 Males	1994 Females	2000 Males	2000 Females
No Education	29.5	42.4	18.5	25.1
Primary Incomplete	27.7	29.1	17.1	17.4
Primary Complete/Some Secondary	32.2	23.0	9.0	10.3
Secondary Complete and Higher	10.5	5.5	54.9	47.1

3. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	3,032	3,415	3,695	3,874	3,884
Births	2,225	2,507	2,713	2,846	2,855
Abortions	352	396	427	447	446
Miscarriages	455	512	554	581	583

4. Unmet Need (%)	1994	1997	2000
Total Unmet Need (15–19)	23.1	18.7	20.0
Total Unmet Need (20–24)	21.7	17.4	18.1

Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1994 was taken from the 1994 Bangladesh Demographic and Health Survey (DHS) report, and for 2000 was taken from the 2000 Bangladesh DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. Total fertility rate (TFR) and age-specific fertility rate (ASFR) for the base year were taken from the Bangladesh DHS 2000 report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 26 per 1,000 (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 1994, 1997, and 2000 Bangladesh DHS reports.

APPENDIX 2. National and International NGOs Working on ARH Issues in Bangladesh

1. AD-DIN Welfare Center (Nutrition)
2. AIDS Awareness Foundation-AAF
3. AISEDUP
4. Al-Falah Bangladesh
5. AROHEE
6. Association for Social and Environmental Development (ASED)
7. Bangladesh Association for Sustainable Development (BASD)
8. Bangladesh Association for Voluntary Sterilization (BAVS)
9. Bangladesh Center for Communication Programs (BCCP)
10. Bangladesh Population and Health Consortium (BPHC)
11. Bangladesh Rural Advancement Committee (BRAC)
12. Bangladesh Rural Reconstruction Movement (BRRM)
13. Bangladesh Women Health Coalition (BWHC)
14. Banchte Shekha
15. CARE- Bangladesh
16. Caritus Center for Mass Education in Science (CMES)
17. Christian Commission for Development in Bangladesh (CCDB)
18. Community Participation and Development (CPD)
19. Concerned Women for Family Planning (CWFP)
20. Confidential Approach to AIDS Prevention (CAAP)
21. Dak Diye Jai Development Council (DC)
22. Dhaka Gonoshastya Kendra (GK)
23. Disadvantaged Adolescents Working NGOs Forum (DAWN Forum)
24. DUS Bangladesh
25. Engender Health (AVSC)
26. Family Development Services and Research (FDSR)
27. Family Planning Association of Bangladesh (FPAB)
28. Ghashful
29. Gono Kalayan Sangstha (GKS)
30. Grameen Jono Kalayan Sangsad (GJKS)
31. Health Action, Heed Bangladesh
32. HIV/AIDS and STD Alliance Bangladesh (HASAB)
33. Integrated Health and Development Center (IHDC)
34. Integrated Social Development Effort (ISDE)
35. Integrated Social Development Project (ISDP)
36. JSI-Urban Family Health Partnership (UFHP)
37. Juba Jiban Advancement Committee
38. Kumudini Welfare Trust of Bengal (Kumudini Hospital)
39. MAMATA
40. Medecins Sans Frontieres, France
41. Mirpur Family Planning Project
42. Mohila Sanghati Parishad
43. Nari Moitree
44. Nari Unnayan Shakti
45. New Life Foundation of Bangladesh
46. Nutrition and Environmental Awareness Programme (NEAP)

47. Organization for Mothers and Infants (OMI)
48. Patharghata Health Development Society
49. Purbasha Juba Shangha (PJS)
50. Rangpur Dinajpur Rural Service (RDRS)
51. Bangladesh Rural Development Society (RDS)
52. Save the Children Fund, USA
53. School Health Pilot Project
54. Service Civil International – Bangladesh
55. Shaheed Smriti Sangha
56. Shapla Neer, Shimantic
57. Society for Development Initiatives (SDI)
58. Society for Project Implementation Research Evaluation and Training (SOPIRET)
59. Socio-Economic Development Association, Bangladesh (SEDAB)
60. Southern Gonounnayan Samity (SGS)
61. Tilottama Voluntary Women's Organization
62. Unnayan Dhara (UD)
63. Village Integrated Development Association (VIDA)
64. Voluntary Association for Rural Development (VARD)
65. Voluntary Paribar Kalyan Association (VPKA)
66. World Vision Bangladesh
67. Young Power in Social Action (YPSA)
68. Young Women Christian Association (YWCA)

APPENDIX TABLES

Table 1. Reproductive Health Situation of Female Adolescent in Bangladesh, 1996–97

	Indicators	Situation
1.	**Social and Economic**	
	Illiteracy (% illiterate: 10–19 years)	51
	% having no access to mass-media	45
	Employment: % employed	25
	% employed but do not earn cash	48
	% earning cash having command over earning	32
2.	**Fertility and Regulation**	
	Current fertility (births per 1,000 women)	147
	Children ever born	0.78
	Children living	0.70
	Adolescent pregnancy (% who have begun childbearing)	35.6
	Contraceptive prevalence rate (CPR)	25
	Never used family planning (%)	47
	Never discussed family planning with husband	45
	Unmet need for family planning (%)	22
	Last birth wanted later (%)	20
3.	**Infant and Child Mortality**	
	Neonatal mortality	70.2
	Post neonatal mortality	35.9
	Infant mortality	106.1
	Child mortality	43.6
	Under five mortality	145
4.	**Maternal and Child Health**	
	Antenatal care received (%)	29
	% think ANC checkup necessary	85
	% not received TT	21
	% reported blood pressure taken during last pregnancy	20
	% reported urine test done during last pregnancy	13
	Home as place of delivery (%)	96
	% received medically competent assistance at delivery	7.4
	Full immunization of child 12–23 months	55.8
	% mothers who are short stature (<145 cm)	19
	% mother acutely malnourished (BMI <18.5%)	50

Sources: NIPORT, 1996–1997; Government of Bangladesh, 1997; Ministry of Health and Family Welfare, 1998; Ali, 1997; Barkat, 2000; MOHFW, 1998; MOHFW, 1999.

Table 2. Reproductive Health Knowledge of Young People in Bangladesh, 2000

Indicators	Unmarried adolescent (N=1,320)	Married adolescent (N= 280)	Unmarried youth (N= 480)	Parents (N=480)	Community Leaders (N= 80)
1. % thinks love is natural	72.6	77.5	80.7	-	-
2. % support more than one marriage	6.9	0.9	4.5	8.6	26.3
3. % support dowry	4.7	9.8	6.3	1.7	0.3
4. % of male having experience of drug abuse	5.3	5.2	7.6	-	-
5. % don't support marriage of girls below 18 years	-	-	-	93.4	99.0
6. % in favor of self-choice of partner for marriage	17.4	36.5	35.0	16.7	32.0
7. % experienced pre-martial sex	6.0	7.4	21.0	-	-
8. % didn't use condom during 1st intercourse (pre-marital)	57.3	39.1	53.1	-	-
9. % unaware about mental changes during adolescence	15.4	21.9	13.6	-	-
10. % unaware about physical changes during adolescence	11.9	16.4	15.6	10.6	-
11. % female unaware about consequences of not maintaining menstrual hygiene	30.4	28.2	28.8	-	-
12. % of female not informed about management of menstruation before onset	24.0	-	25.0	23.4	-
13. % unaware about cause of menstruation	55.4 (female)	58.4 (female)	57.7 (female)	47.8	21.3
14. % unaware about HIV/AIDS	27.9	48.1	17.2	-	-
15. % unaware about Gonorrhoea	86.2	74.7	62.1	-	-
16. % unaware about Syphilis	87.5	60.1	51.1	-	-
17. % didn't report anybody for treatment of RTI	71.7 (female)	58.0 (female)	65.2 (female)	-	-
18. % uninformed by health/family planning worker about STI treatment	90.7	91.1	83.7	-	-
19. % unaware of consequences of unprotected sexual act	41.5	57.0	30.7	31.7	12.7
20. % unaware about how a person can be infected with HIV/AIDS	44.5	67.7	39.4	-	-
21. % thinks adolescent should be informed about prevention of STI/HIV/ AIDS	-	-	-	90.1	96.0
22. % thinks adolescent should be counseled for family planning	-	-	-	85.8	94.3
23. % knows about family planning	91.0	97.7	97.0	99.5	99.7
24. family planning use rate (CPR)	-	28.0	-	-	-
25. % unaware of EOC	-	60.0	-	-	-
26. % never heard of abortion	35.4	24.1	11.0	3.2	0.0
27. % never heard of MR	56.7	42.1	66.5	18.6	14.7
28. % unaware about causes of night blindness	24.7	34.4	22.6	-	-
29. % ever participated in training/discussion on sexuality	12.8	9.5	12.1	-	-
30. % think negotiation skill needs to be imparted to young people (to avoid sexual act)	85.2	88.2	94.2	89.2	99.3
31. % unaware about consequences of violence against women	15.0	22.5	9.9	3.9	-
32. % consider information on SRH as a right for young people	83.3	88.2	93.0	99.1	99.7

Note: This study was carried out in 12 project areas of the Family Planning Association of Bangladesh and in four non-project areas.

Source: Barkat, et al., 2000.

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