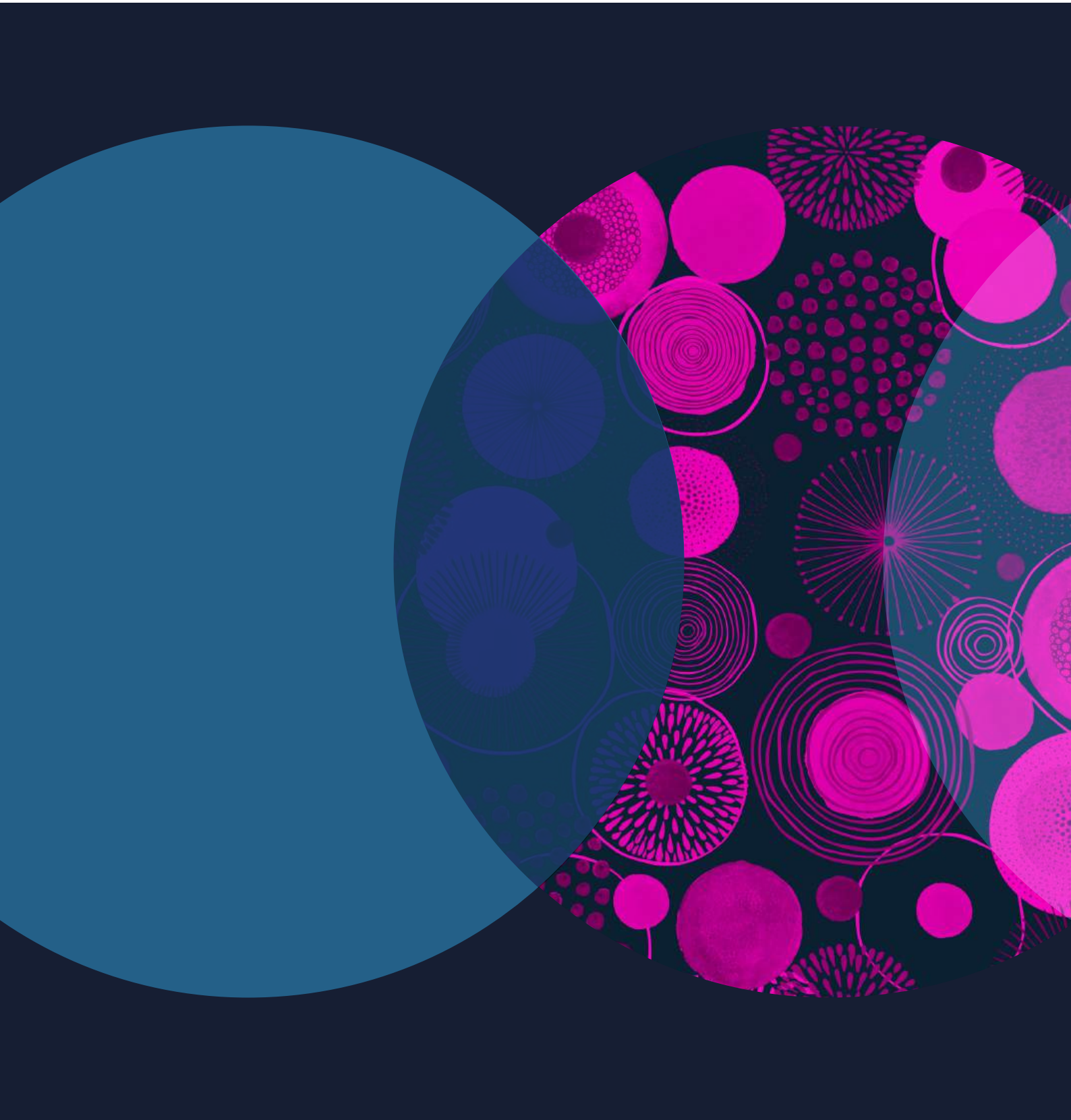
SERAC-*Bangladesh*
(A youth focused rights and development organization)

IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON OUT OF SCHOOL YOUNG PEOPLE IN BANGLADESH

SRH Evidence Generation Mini-Pilot Report



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This report is part of the Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA) initiative to generate evidence on sexual and reproductive rights in Asia and the Pacific.

IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON OUT OF SCHOOL YOUNG PEOPLE IN BANGLADESH

SRH Evidence Generation Mini-Pilot Report

SERAC-BANGLADESH (2021)

ASIA PACIFIC ALLIANCE
FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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apa
FOR SEXUAL & REPRODUCTIVE HEALTH & RIGHTS

CONTENTS

INTRODUCTION

Bangladesh has practiced a progressive rate of contraceptive prevalence rate in less than forty years from 8% in 1975 to 62% in 2014[1], whereas the total fertility rate is 2.0%[2]. Though sexual and reproductive health and rights (SRHR) are fundamental rights for youth, they continue to face challenges in accessing them. For example, the topic of SRHR in Bangladesh remains difficult to discuss openly, particularly among adolescents despite its importance in this stage of their life.

The need for SRHR and family planning (FP) information and services are increasing, close to 62% to 82%[3]. Despite this advancement, almost one-third of pregnancies are still unintended because of unwillingness to use contraceptives. Bangladesh has the highest adolescent fertility rate in South Asia where 1 girl in 10 has a child before the age of 15 whereas 1 in 3 adolescents becomes a mother or pregnant by the age of 19 (UNDP, 2016). The BDHS 2014 also found that about 31% of adolescent girls begin childbearing before the age of 20; one in four give birth and 6% are pregnant with their first child (BDHS, 2014). Family Planning Department (2013) also added that only 47% of adolescent married girls between 15-19 years have access to contraceptive methods in Bangladesh.

The SDGs call for universal access to family planning by 2030. Today, more than 300 million women have access to modern family planning, but over 200 million do not, and 25 million unsafe abortions take place every year worldwide[4]. Despite a target to reach 120 million more women and girls in the world's 69 poorest countries with modern contraceptives by 2020, there have been only 46 million new users, so increment of commitment periods must be considered. Again, only a few women and girls who are educated, have a little knowledge about SRHR and FP. Almost 36 percent of women[5] or girls do not have ideas or knowledge about SRHR and are mostly ignored or deprived of their sexual and reproductive rights. Considering their needs, SERAC-Bangladesh with the support of Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA), has conducted a mini pilot study to get the actual status of women's access to SRH services, especially those who are outside of any institutionalized study.

[1] Bangladesh Demographic and Health Survey 2017-18: Key Indicators. National Institute of Population Research and Training (NIPORT), and ICF. 2019

[2] UNFPA Bangladesh, *United Nations Population Fund*, accessed June 5, 2021. https://www.unfpa.org/data/BD

[3] *COVID-19: Bangladesh Multi-Sectoral Anticipatory Impact and Needs Analysis.* Needs Assessment Working Group Bangladesh, BDHS, 2020

[4] *Investing in Sexual and Reproductive Health in Low- and Middle-Income Countries.* Guttmacher Institute. July 2020

[5] Bangladesh Bureau of Educational Information & Statistics, 2011. BANBEIS

METHODOLOGY

The study was undertaken during July-September 2020. It was commissioned to understand the real-life experiences of comprehensive sexuality education (CSE) and SRH services provided to 50 out-of-school adolescent girls aged 13–19 who live in the slum areas of Dhaka city.

This is a descriptive study, and the aim of this study is not to 'test' respondent's knowledge, and not ask personal questions about their own behavior or decisions. Rather, the aim is to know how they have accessed CSE, what types of information they have been given, what more information they need, and how easy it is for young/unmarried people to access SRH services in their area.

SAMPLE DESIGN

Information was collected using quota sampling (non-random sampling) for selecting 50 out-of-school adolescent girls aged between 13 to 19 who live in Rupnagar slum at Mirpur area in Dhaka city.

DATA COLLECTION

Primary data sources were utilized to collect the required information. The information was collected from 58 out-of-school married and unmarried female adolescents from whom 50 participated in an in-depth interview process and 8 joined the Focused Group Discussion (FGD). Both qualitative and quantitative data were collected. For quantitative data a structured (close-ended) questionnaire was developed, whereas the qualitative data was collected through a semi-structured (open and close-ended) questionnaire.

DATA ANALYSIS

Relevant statistical techniques were used through univariate analysis such as frequency distribution table to analyse the collected information. The key results were presented through graphs like pie chart and bar chart, including the interpretation of the findings.

FINDINGS OF THE STUDY

DEMOGRAPHIC DATA PRESENTATION

AGE OF THE RESPONDENTS

This Figure (1.1) shows that out of fifty respondents, twenty (40%) were 13 years old (the ratio of these respondents were significantly high because the targeted group of the mini-pilot was 13-19 years old adolescent girls living at slums in Dhaka), and the lowest one (2%) respondent belonged to 19 years of age.

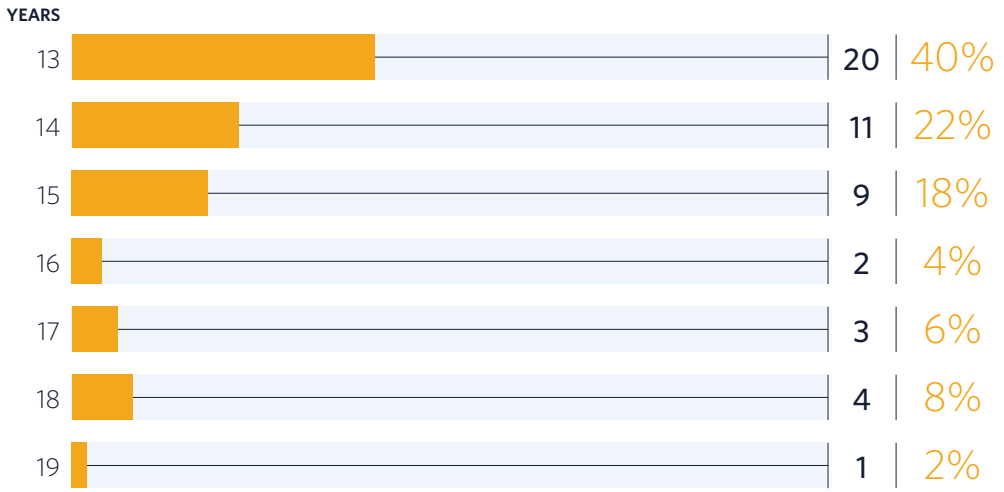


FIGURE **1.1**

AGE OF THE RESPONDENTS

MARITAL STATUS OF THE RESPONDENTS

This Figure (1.2) shows that sixteen (32%) of the respondents were married and thirty-four (68%) were unmarried adolescent girls who participated in the survey.

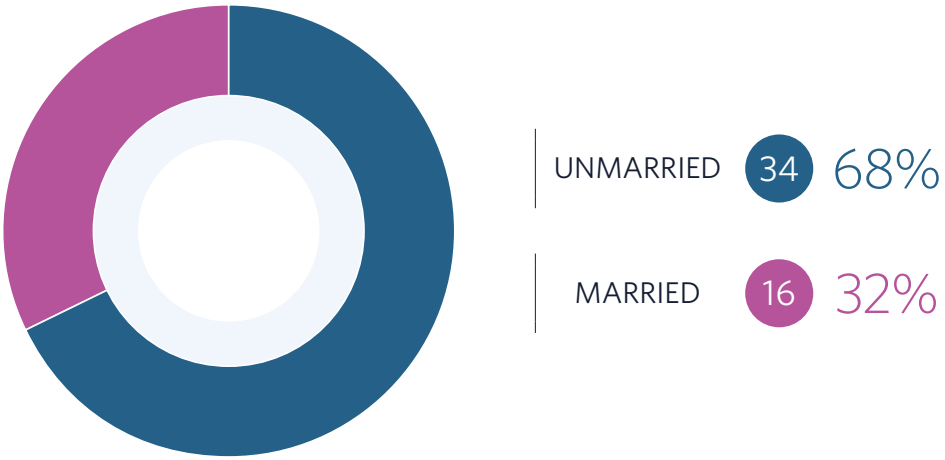


FIGURE **1.2**

MARITAL STATUS OF THE RESPONDENTS

DURATION OF RESPONDENT'S ACADEMIC LIFE

The following Figure (1.3) indicates eleven (22%) of the respondents attended on average 5 years (this is the highest ratio of the respondents) while four (8%) of the respondents respectively said that they attended school for about 2, 3 and 9 years, and the same number of the respondents never attended any school. On the other hand, only one (2%) of the respondents attended the school for 12 years.

FIGURE **1.3**

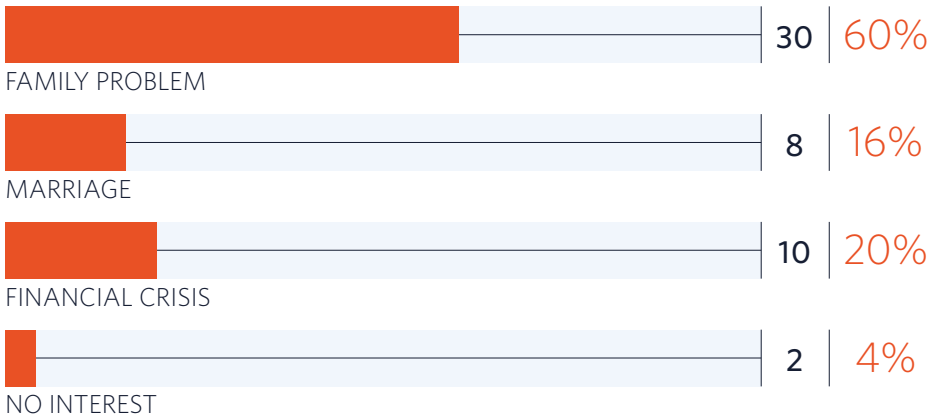
DURATION OF RESPONDENT'S ACADEMIC LIFE

REASONS FOR DROPPING OUT OF SCHOOL

The following Figure (1.4) indicates the number of reasons demonstrated by the respondents for leaving school. Of the fifty respondents, thirty (60%) mentioned that they left school for family problems and respectively ten (20%) and eight (16%) of them said that they faced financial crisis, and early marriage. Only two (4%) of the participating adolescents were disinterested to answer this question.

FIGURE **1.4**

RESPONDENTS REASONS FOR DROPPING OUT OF SCHOOL



ECONOMIC SUPPORT OF THE FAMILY

The following Figure (1.5) shows that out of fifty respondents, thirty-six (72%) said that they do not provide any financial support to their family while only fourteen (28%) stated that they provide financial support to their family.

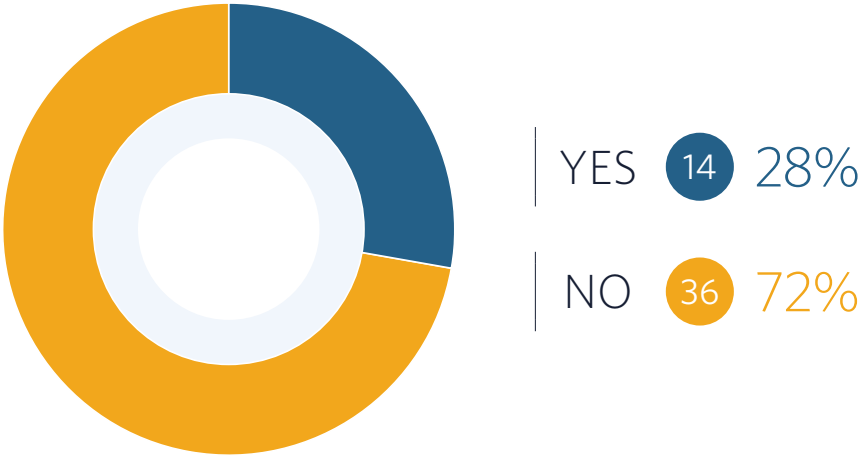


FIGURE **1.5**

RESPONDENT'S ECONOMIC SUPPORT OF THEIR FAMILY

EMPLOYMENT TYPE

The following Figure (1.6) was a follow-up question from the previous (Figure 1.5). If respondents answered 'yes', that they support their family; then they were asked what it is that they do to support their family. Of the fourteen (28%) respondents that work to support their family, nine (18%) of the respondents support their family through work as garment workers and five (10%) work as housekeepers.

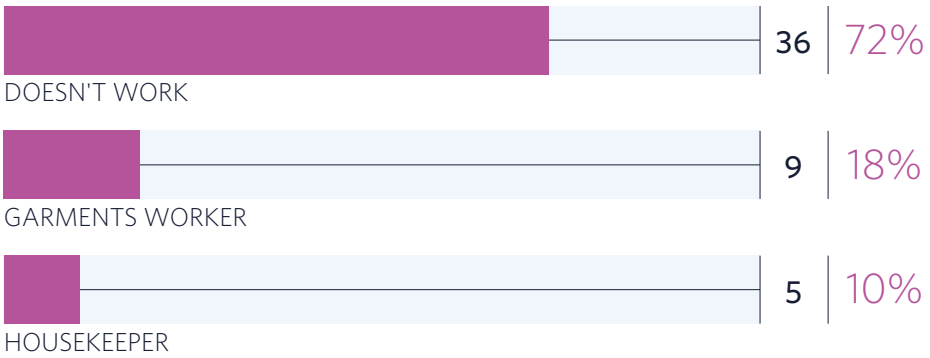


FIGURE **1.6**

RESPONDENT'S EMPLOYMENT TYPE

FINDINGS OF THE STUDY

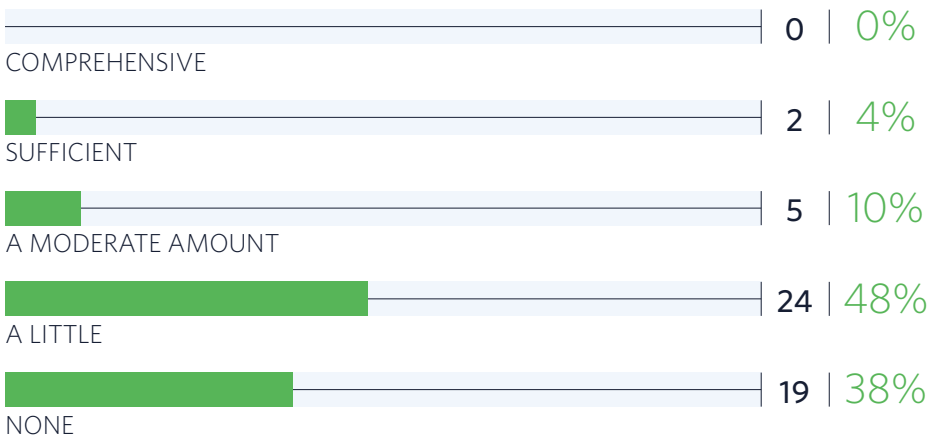
KNOWLEDGE ABOUT COMPREHENSIVE SEX EDUCATION / PRAJANAN SWASTHYA

INFORMATION ON SEXUAL AND REPRODUCTIVE HEALTH

The following Figure (1.7) indicates that twenty-four (48%) of the respondents said that they have little information on SRHR, and no one has comprehensive information about SRHR. And about nineteen (38%) respondents have no information about SRHR, where only two (4%) respondents have sufficient information about SRHR.

FIGURE **1.7**

RESPONDENT'S INFORMATION ON SRHR

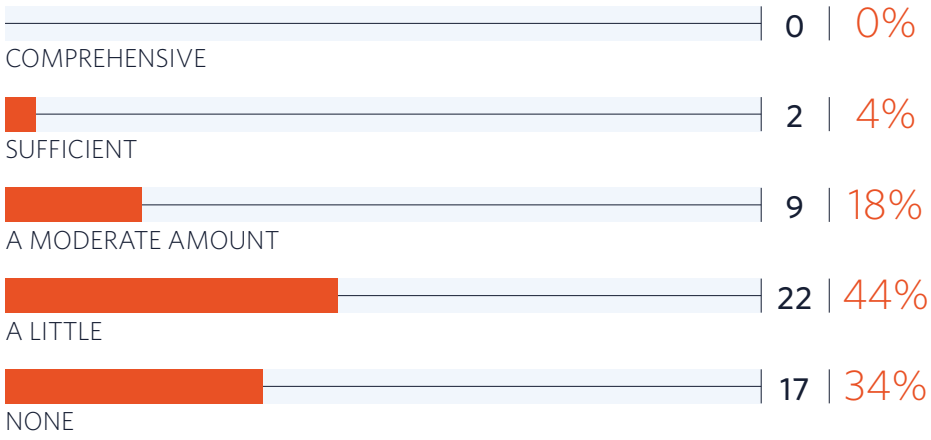


INFORMATION ON CHILD MARRIAGE

Figure 1.8 shows that twenty-two (44%) of the respondents said that they have little information on child marriage whereas seventeen (34%) respondents have no information about child marriage. While two (4%) of the respondents said that they have sufficient information about child marriage, it is important to note that none have comprehensive information on it.

FIGURE **1.8**

RESPONDENT'S INFORMATION ON CHILD MARRIAGE



INFORMATION ON MENSTRUATION

The following Figure (1.9) indicates that twenty-seven (54%) of the respondents have little information about menstruation and seven (14%) have no information about menstruation. Two (4%) respondents have sufficient information and comprehensive information about menstruation and twelve (24%) of the respondents have a moderate amount of information about menstruation in general.

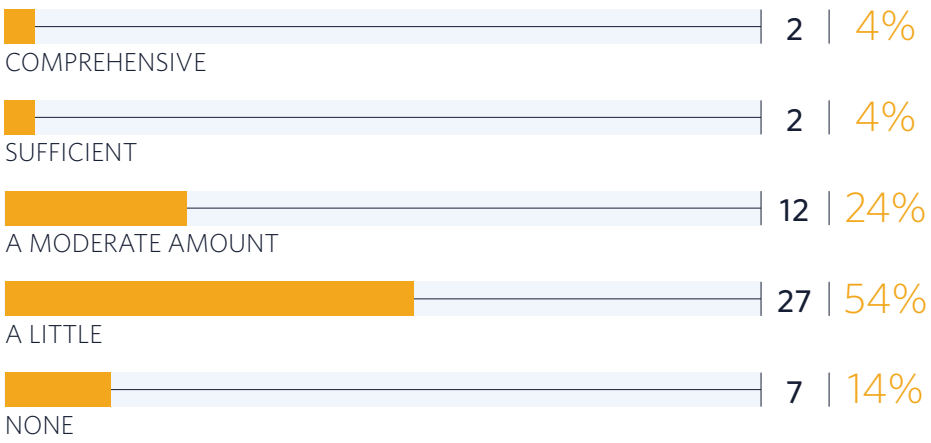


FIGURE **1.9**

RESPONDENT'S INFORMATION ON MENSTRUATION

INFORMATION ON PREGNANCY

Figure 2.0 shows that sixteen (32%) of the respondents have little information about pregnancy whereas twenty-one (42%) of the respondents have no information about pregnancy, which is significantly a higher ratio. About three (6%) of the respondents have sufficient information, eight or (16%) of the respondents have moderate information and two (4%) of the respondents have comprehensive information on pregnancy which is significantly a lower ratio.

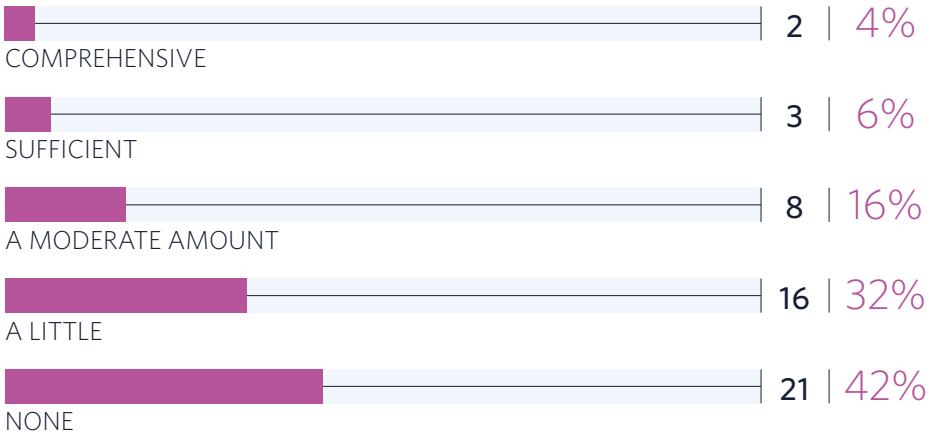


FIGURE **2.0**

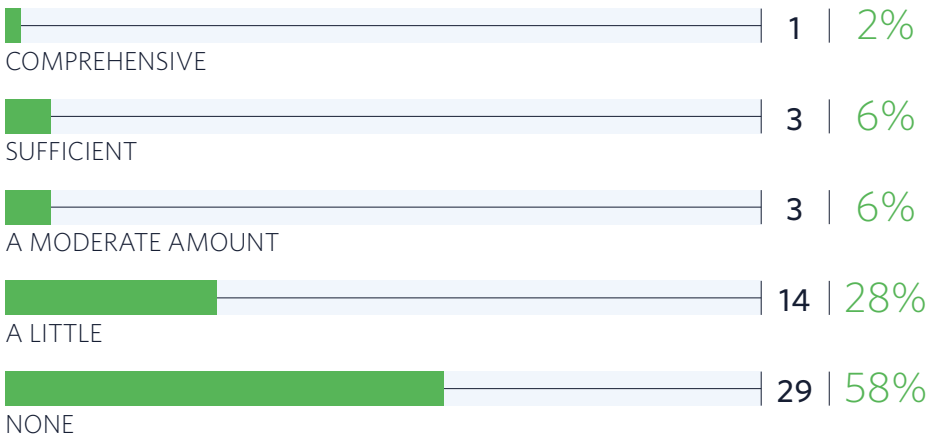
RESPONDENT'S INFORMATION ON PREGNANCY

INFORMATION ON CONTRACEPTION

The following Figure (2.1) indicates that fourteen (28%) of the respondents have a little information, whereas most, or twenty-nine (58%) of respondents, have no information about contraception. Three (6%) of the respondents have sufficient information and have moderate information about contraception respectively. And one (2%) of the respondents have comprehensive information about contraception - that is significantly low.

FIGURE **2.1**

RESPONDENT'S INFORMATION ON CONTRACEPTION

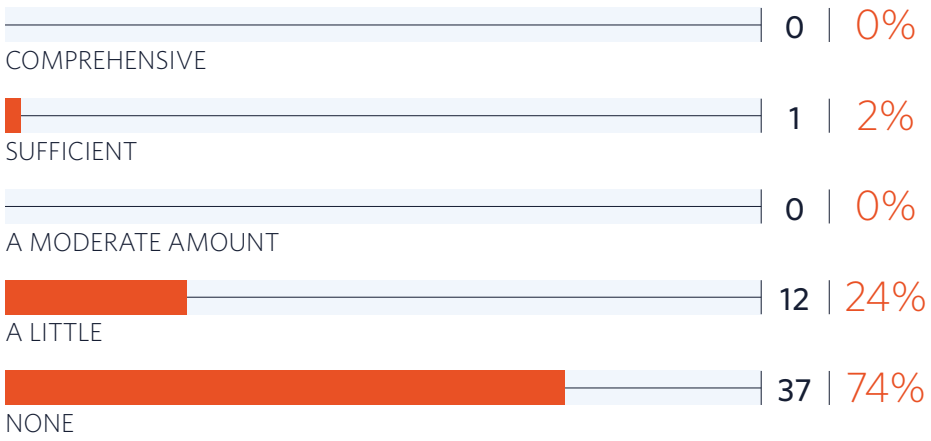


INFORMATION ON HIV

The following Figure (2.2) revealed that twelve (24%) of the respondents have a little information where most of the respondents, thirty-seven (74%), have no information about HIV. One (2%) respondent had sufficient information about HIV and none of the respondents had moderate, and/or comprehensive information about HIV.

FIGURE **2.2**

RESPONDENT'S INFORMATION ON HIV



INFORMATION ON GENDER-BASED VIOLENCE

Figure 2.3 shows that twenty-seven (54%) of the respondents have little information about gender-based violence (GBV), which is significantly a higher ratio, while twelve (24%) of the respondents have no information. Four (8%) of the respondents have sufficient information and six (12%) of the respondents have moderate information about GBV. Only one (2%) respondent has comprehensive information about GBV and this is a significant low ratio.

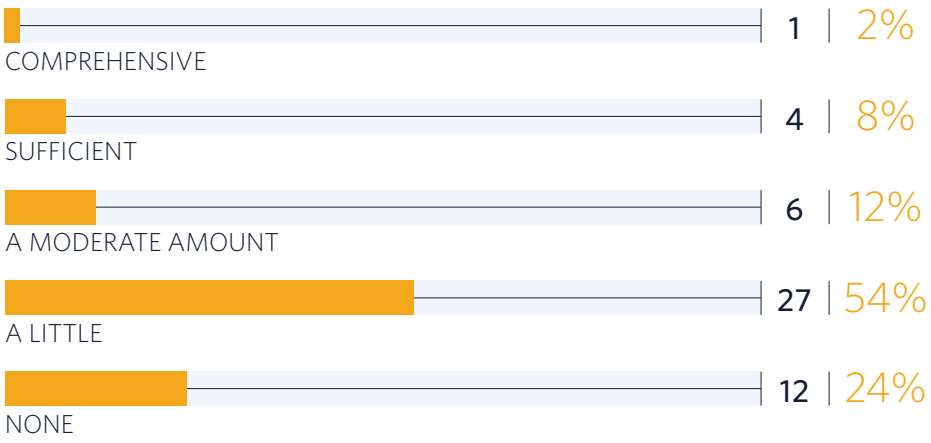


FIGURE **2.3**

RESPONDENT'S INFORMATION ON GENDER-BASED VIOLENCE

ADDITIONAL INFORMATION DESIRED

The following Figure (2.4) indicates that out of fifty respondents, forty-three (86%) would not like additional more information on the previous topics, and this is significantly high. Only one (2%) of the respondents would like to know all topics in depth, SRHR and dangers of pregnancy after the age of 30. Four (8%) of the respondents wanted to know more about gender-based violence (GBV) and its preventative strategies.

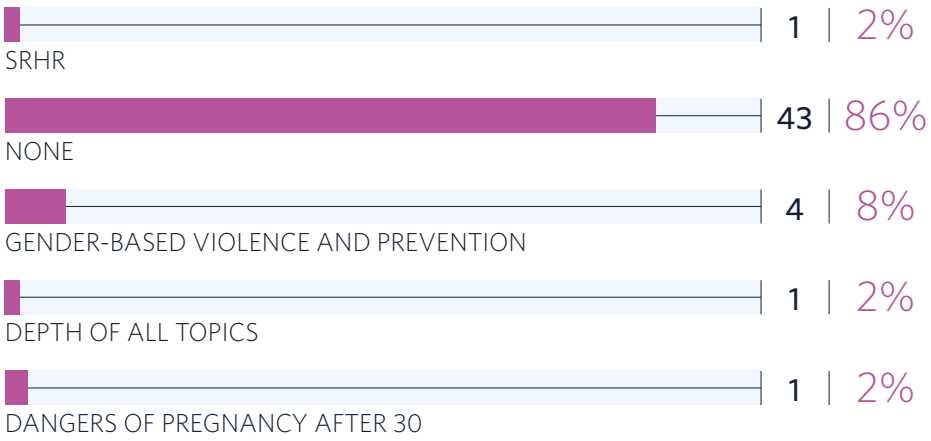


FIGURE **2.4**

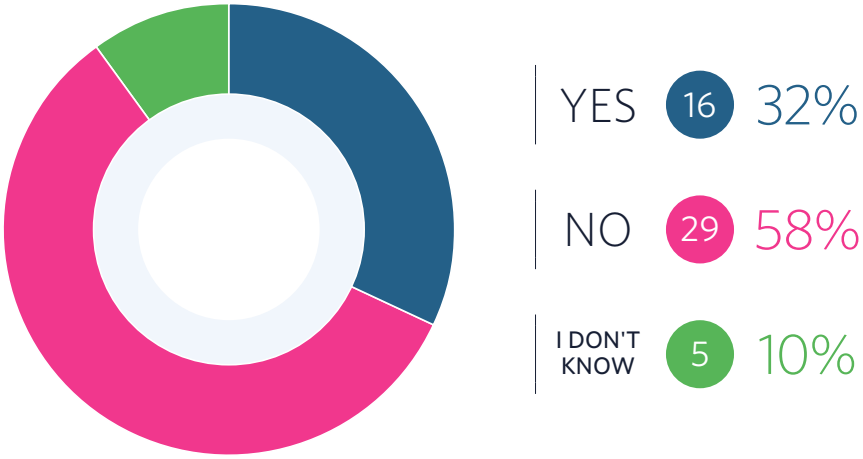
ADDITIONAL INFORMATION RESPONDENTS WOULD LIKE ABOUT THE PREVIOUS TOPICS

COMPREHENSIVE SEXUALITY EDUCATION AT SCHOOL

Figure 2.5 indicates that twenty-nine (58%) of the respondents did not receive any information on comprehensive sexuality education (CSE) during their time at school which is significantly high. Sixteen (32%) of the respondents received information on CSE and five (10%) of the respondents said that they do not know about CSE; which is a significantly low ratio.

FIGURE **2.5**

COMPREHENSIVE SEXUALITY EDUCATION RESPONDENTS RECEIVED IN SCHOOL

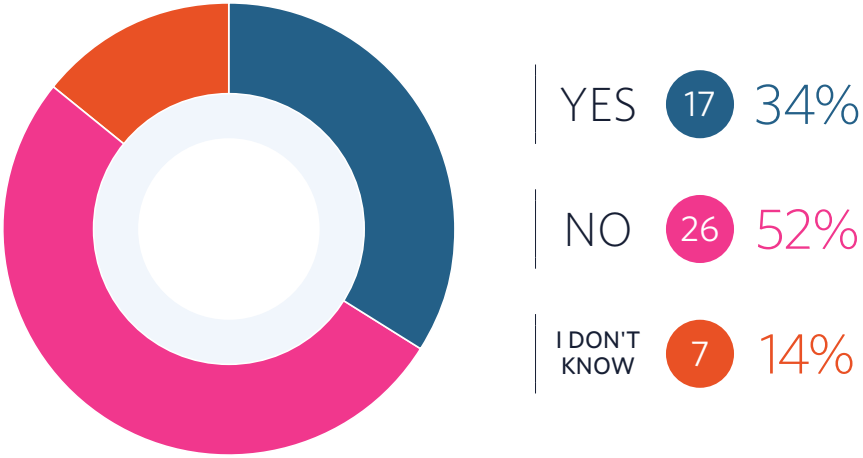


ADOLESCENT HEALTH-RELATED TOPICS LEARNED IN SCHOOL

The following Figure (2.6) shows that twenty-six (52%) of the respondents said that they did not learn about adolescent health during their time in school. About seventeen (34%) of the respondents answered yes to learning about it, and seven (14%) of the respondents answered no to learning about it during their time in school. This is a significantly low ratio.

FIGURE **2.6**

ADOLESCENT HEALTH-RELATED TOPICS RESPONDENTS LEARNED IN SCHOOL



SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE

Figure 2.7 shows that thirty (60%) of the respondents mentioned that no, they did not learn about SRHR in school; this is significantly high. And thirteen (26%) of the respondents learned about SRHR in school. Only seven (14%) respondents answered that they do not know (due to lack of clarity or confusion if they learned it in school).

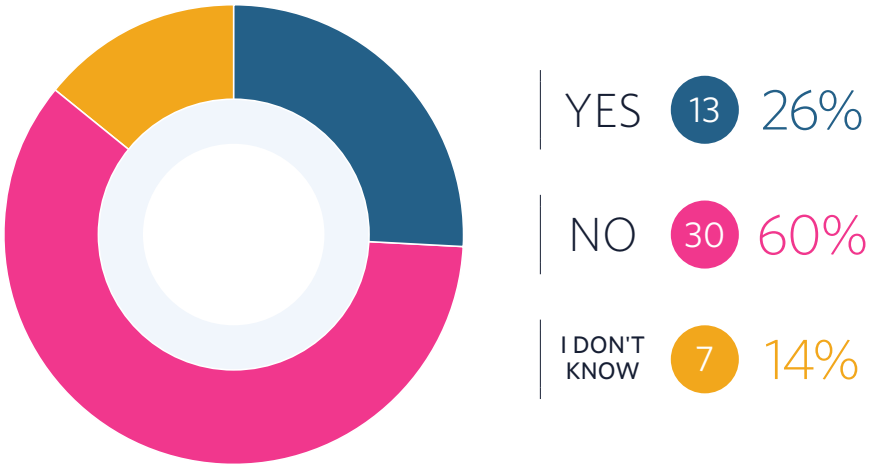


FIGURE **2.7**

SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE RESPONDENTS OBTAINED AT SCHOOL

ADDITIONAL INFORMATION

Figure 2.8 shows that out of fifty respondents, twenty-six (52%) of the respondents had no comment if they wish to receive further information on this issue from school; it is noted that the ratio is significantly high (they have no interest and not enough knowledge to ask for further information). Two (4%) of the respondents expressed that they would like to learn more about SRHR, menstruation respectively from school. And only one (2%) of the respondents expressed a wish to learn about family planning, that the school had taught them more profoundly or accurately regarding adolescent health (without skipping topics), and that the school should have deep knowledge on adolescent health issues so topics could be taught without hesitation.

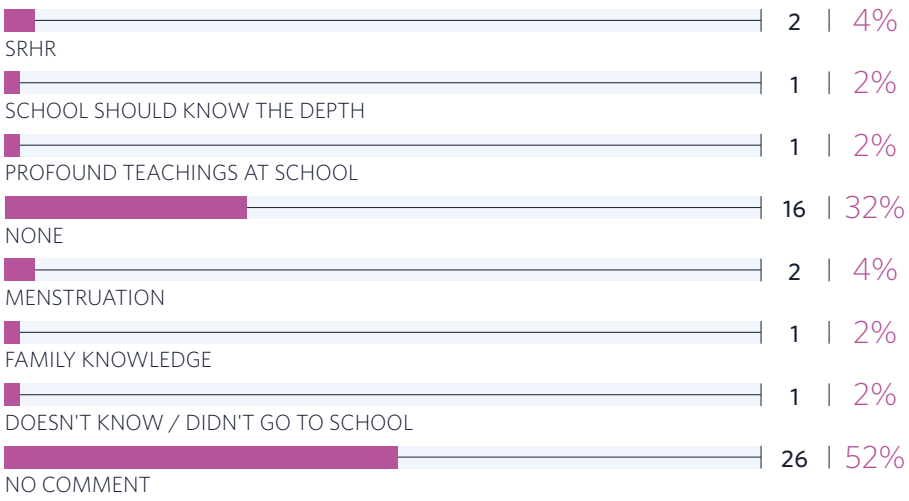


FIGURE **2.8**

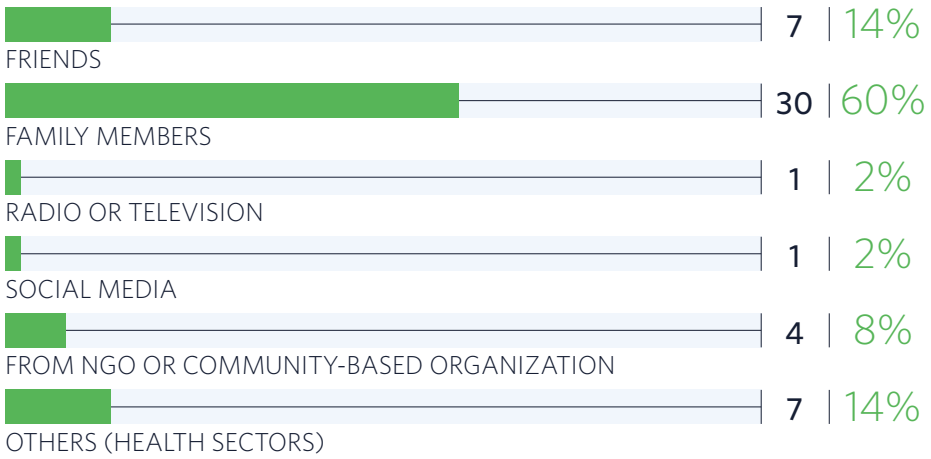
RESPONDENT'S INTEREST IN ADDITIONAL INFORMATION FROM SCHOOL

SOURCES OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

The following Figure (2.9) shows that out of fifty respondents, thirty (60%) of the respondents have received most of their information on sexual and reproductive health (SRH) from their family members (other than school). Seven (14%) of the respondents have received most of their information from their friends and others (health workers) and four (8%) of the respondents have received most of their information from an NGO or CBO. Only one (2%) respondent said that other than the school, most of the information was received from radio or television and social media, and others (health workers).

FIGURE **2.9**

RESPONDENT'S SOURCE OF SRH INFORMATION

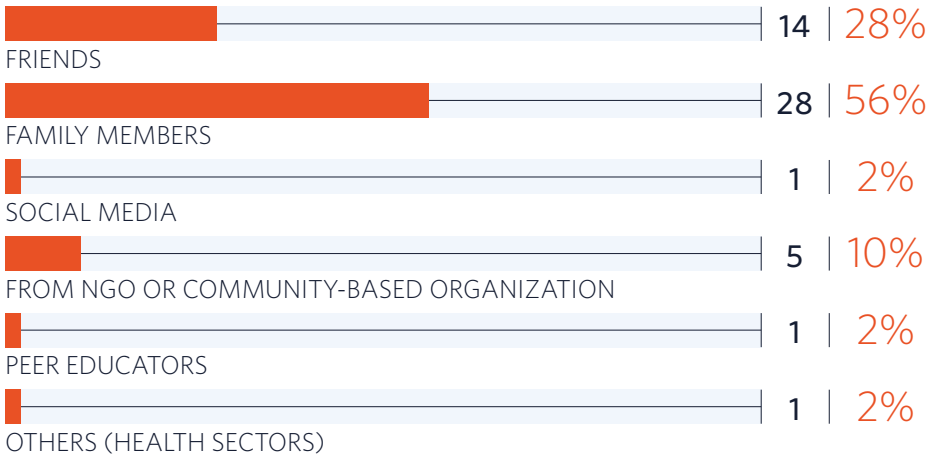


PREFERENCE FOR RECEIVING INFORMATION IN THE FUTURE

Figure 3.0 shows that in the future, twenty-eight (56%) respondents would prefer to receive information on any of the previous topics from family members. About fourteen (28%) of the respondents would prefer to receive information from friends. And five (10%) respondents would prefer to receive information from an NGO or CBO. Here the figure also indicates that one (2%) of the respondents would prefer to receive information from social media, peer educators and others (health workers); it is a significantly low ratio.

FIGURE **3.0**

RESPONDENT'S PREFERENCE FOR RECEIVING INFORMATION RELATED TO SRHR IN THE FUTURE



PERCEPTIONS ABOUT CHILD MARRIAGE

The following Figure (3.1) indicates that thirty-three (66%) respondents agree that child marriage is an offence according to the child marriage prevention law, and it is significantly high. Nine (18%) of the respondents do not agree with that opinion and only eight (16%) of the respondents stated that they do not know about the topic.

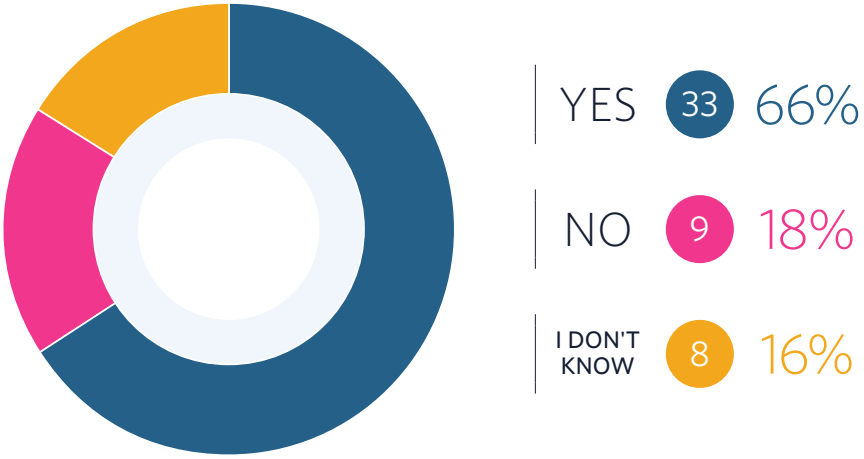


FIGURE **3.1**

RESPONDENT'S PERCEPTIONS ABOUT CHILD MARRIAGE IN ACCORDANCE WITH THE CHILD MARRIAGE PREVENTION LAW

CONTRACEPTIVE METHODS AND REPRODUCTIVE HEALTH COMMODITIES IN THE COMMUNITY

Figure 3.2 shows that out of fifty respondents, in regards to the availability of the contraceptive methods and reproductive health commodities, twenty (40%) of the respondents said the menstrual pad is mostly available in their community; this is significantly high. About fifteen (30%) of the respondents said that they do not know about the availability of any kind of contraceptive method and reproductive health commodity. And eight (16%) respondents said that condoms are available in their community. Only four (8%) said the oral pill is available and three (6%) respondents said other contraceptives and reproductive health commodities are available respectively in their community.

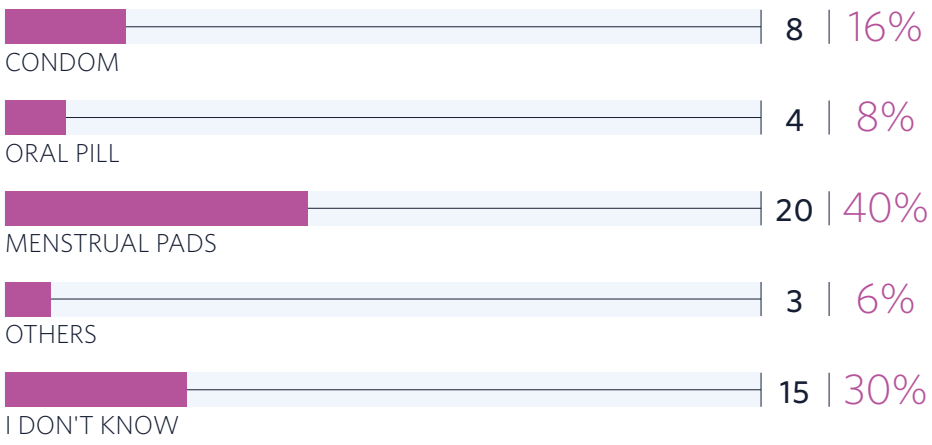


FIGURE **3.2**

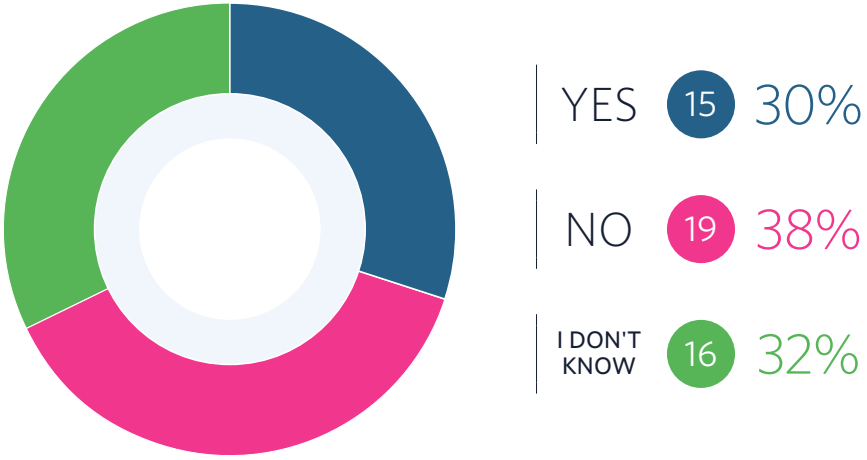
AVAILABILITY OF CONTRACEPTIVE METHODS AND REPRODUCTIVE HEALTH COMMODITIES IN RESPONDENT'S COMMUNITY

URBAN HEALTH SERVICE CENTER IN RESPONDENT'S AREA

The following Figure (3.3) revealed that nineteen (38%) of the respondents answered no to having an Urban Health Center (UHSC) in their area, while only fifteen (30%) respondents answered yes to the availability of a UHSC in their area.

FIGURE **3.3**

AVAILABILITY OF URBAN HEALTH SERVICE CENTERS IN RESPONDENT'S AREA

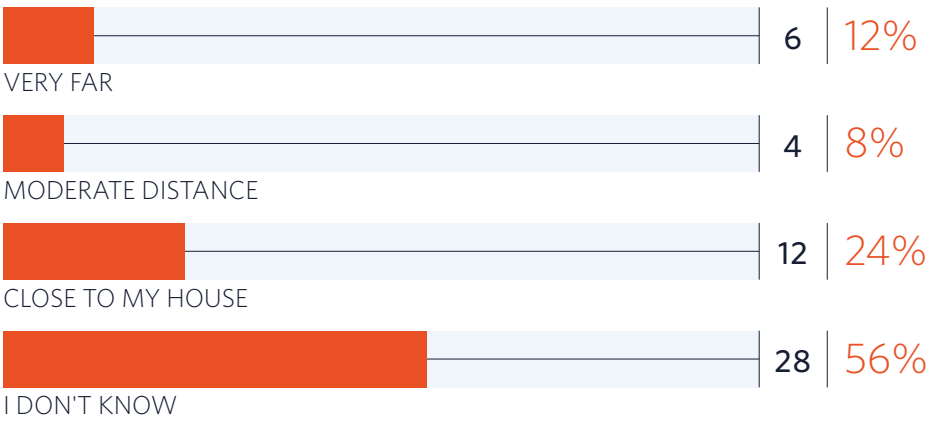


DISTANCE TO THE NEAREST URBAN HEALTH SERVICE CENTER

The following Figure (3.4) reveals that out of fifty respondents, thirty-five (70%) do not know how far the nearest UHSC service center is, and this is significantly on the higher end. About twenty-two (44%) of the respondents said that the UHSC service center is close to their house and three (6%) respondents said that it is very far from their house. And one (2%) respondent said that the UHSC is a moderate distance from their home.

FIGURE **3.4**

RESPONDENT'S DISTANCE TO THE NEAREST URBAN HEALTH SERVICE CENTER



PAYMENT FOR SERVICES AT THE URBAN HEALTH SERVICE CENTER

Figure 3.5 shows that thirty-six (72%) of the respondents answered they have no idea of payment at the UHSC: it is significantly high. Thirteen (26%) of the respondents said that they need to pay to obtain services at the UHSC, and only one (2%) respondent said that they do not need to pay for the services at the UHSC.

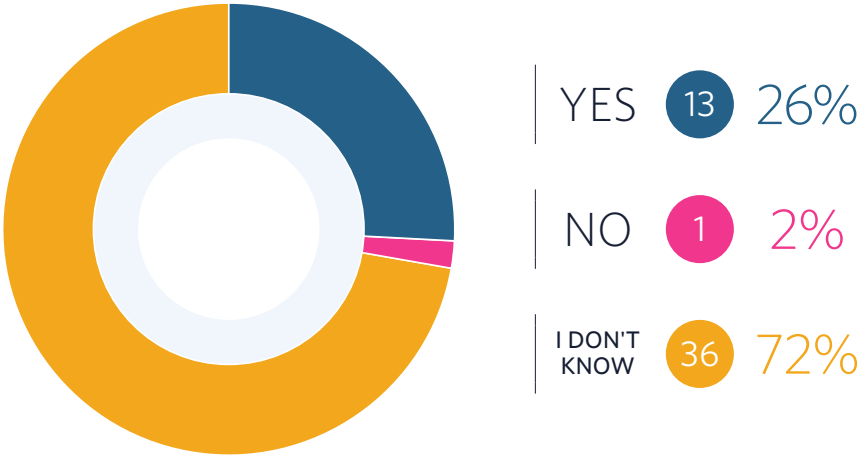


FIGURE **3.5**

RESPONDENT'S KNOWLEDGE ON PAYMENT FOR SERVICES AT THE URBAN HEALTH SERVICE CENTER

AVAILABILITY OF YOUTH FRIENDLY SERVICES

Figure 3.6 shows that thirty-nine (78%) of the respondents have no idea whether the UHSC services are friendly or not for young people. About eight (16%) respondents mentioned having friendly UHSC services for young people where only three (6%) respondents answered not having any UHSC being friendly for young people.

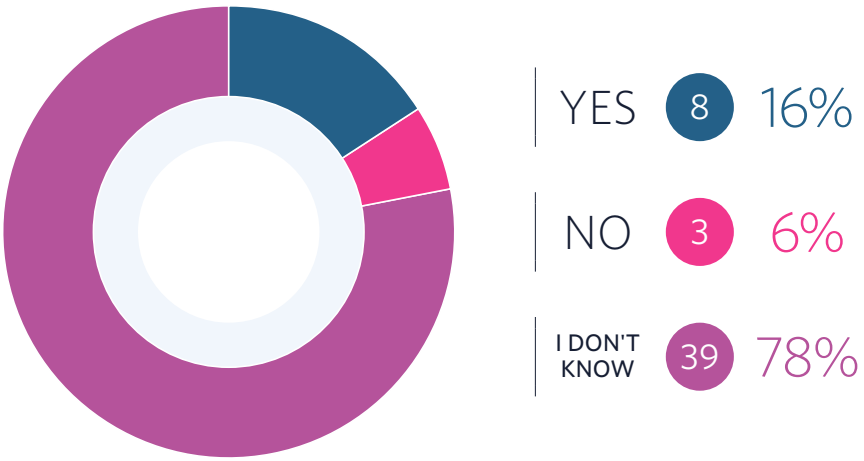


FIGURE **3.6**

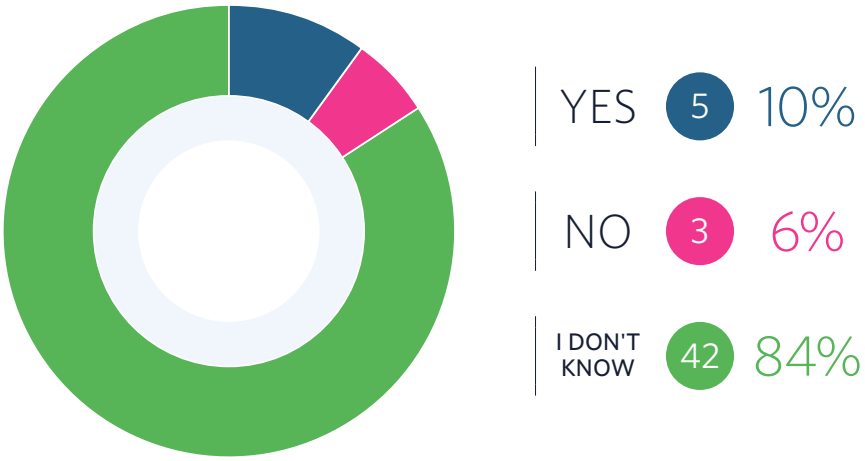
RESPONDENT'S KNOWLEDGE OF AVAILABILITY OF YOUTH FRIENDLY SERVICES

AVAILABILITY OF URBAN HEALTH SERVICE CENTERS FRIENDLY FOR UNMARRIED YOUNG PEOPLE

The following Figure (3.7) shows that forty-two (84%) of the respondents have no idea whether the UHSC is friendly or not, especially for unmarried young people and it is significantly high. About five (10%) respondents said that the services are friendly for unmarried young people and only three (6%) respondents said that the services are not friendly at all to unmarried people.

FIGURE **3.7**

RESPONDENT'S KNOWLEDGE ABOUT WHETHER URBAN HEALTH SERVICE CENTERS ARE FRIENDLY FOR UNMARRIED YOUNG PEOPLE

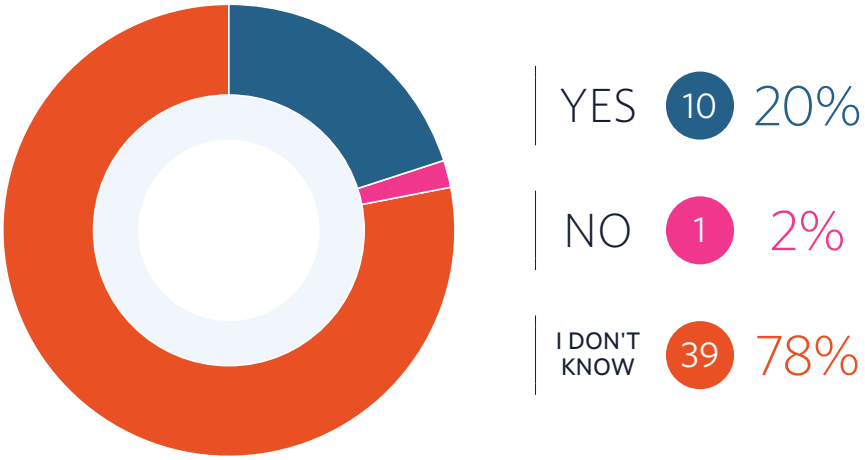


OTHER SERVICE CENTERS

Figure 3.8 shows that thirty-nine (78%) of the respondents said they have no idea about other service centers in their area, and it is a significantly high ratio. Ten (20%) respondents said that they have no other service centers other than UHSC in their area. And only one (2%) respondent said that other service centers besides UHSC are available; it is significantly low.

FIGURE **3.8**

AVAILABILITY OF OTHER SERVICE CENTERS IN THE RESPONDENT'S AREAS



OTHER SERVICE CENTERS: YOUTH-FRIENDLINESS

Figure 3.9 shows that forty-five (90%) of the respondents answered that they don't know whether other service centers in their area are youth friendly or not, and it is significantly high. About two (4%) respondents did not think that other service centers are youth friendly while only three (6%) respondents said that yes, other service centers in their area are youth friendly, and it is significantly low.

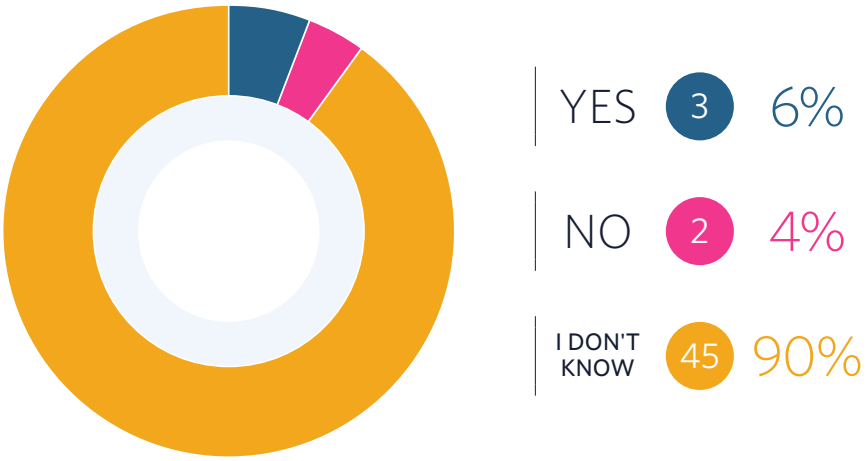


FIGURE **3.9**

OTHER SERVICE CENTERS IN RESPONDENT'S AREA FRIENDLY FOR YOUNG PEOPLE

OTHER SERVICE CENTERS: UNMARRIED YOUNG PEOPLE

The following Figure (4.0) indicates that out of total respondents, forty-five (90%) of the respondents mentioned that they do not know whether other service centers in their area are friendly or not for unmarried young people, and it is significantly very high. Four (8%) respondents said that other service centers are not friendly for unmarried young people while only one (2%) of them said that other service centers in their area are friendly for unmarried people, and it is significantly very low.

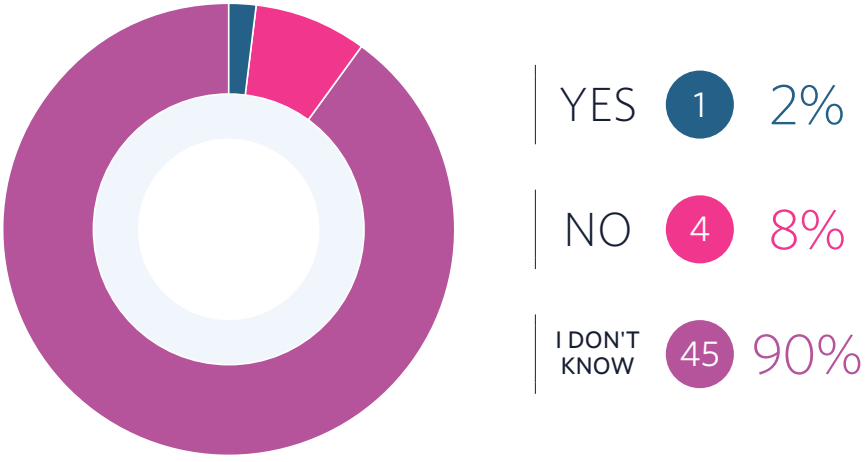


FIGURE **4.0**

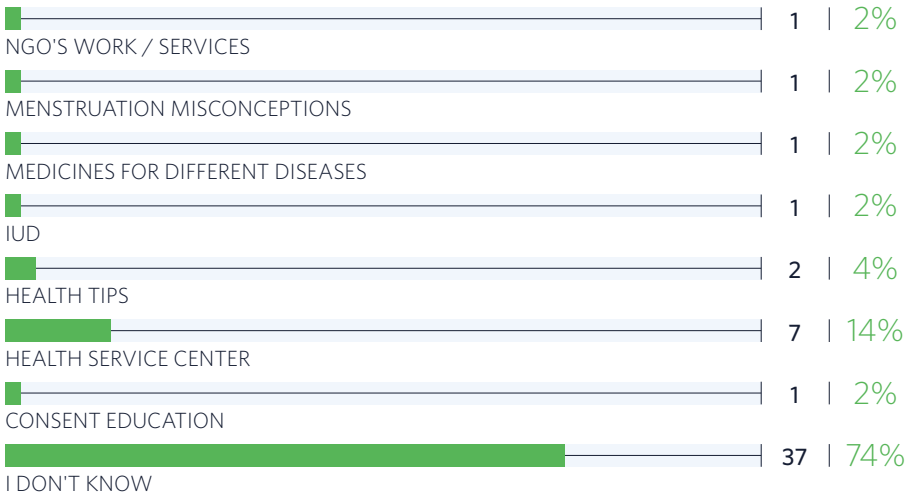
RESPONDENT'S KNOWLEDGE OF AVAILABILITY OF OTHER SERVICE CENTERS THAT ARE FRIENDLY FOR UNMARRIED YOUNG PEOPLE

AVAILABILITY OF ADDITIONAL SERVICES OR PRODUCTS FOR YOUNG PEOPLE

The following Figure (4.1) indicates that thirty-seven (74%) respondents mentioned that they do not know about additional services or products that could be to their liking, including availability of such products in their area, and it is significantly high. About seven (14%) respondents would like to have a health service center available for young people in their area. And two (4%) respondents would like to have available any health information on youth-health priorities including reproductive health and mental health information, while only one (2%) respondent expressed that it would be better to have NGO services available, the reduction of misconceptions about menstruation, medicine for diseases, intrauterine device (IUD), and education about consent for young people; this ratio is significantly low.

FIGURE **4.1**

ADDITIONAL SERVICES OR PRODUCTS FOR YOUNG PEOPLE THAT RESPONDENTS WOULD LIKE TO BE AVAILABLE



FINDINGS OF THE FOCUS GROUP DISCUSSIONS

Eight out-of-school girls, both married and unmarried, were selected for focus group discussions. The FGDs addressed the impact of CSE for out-of-school young people, and participants shared their knowledge, practices and suggestions for future action. Qualitative data was collected using key questions on the topic, and the key findings from those discussions follow.

KNOWLEDGE ABOUT CSE

Some adolescents have no formal education. In some cases, some information included in madrasa curriculum but the information is not given in classroom, so it is difficult to gain knowledge. In a few cases, they received knowledge from their employers, i.e., where they work as a housemaid. In some cases, could they discuss with their mother/in-laws but thought the information on CSE was misinterpreted to them.

"In our Madrasa curriculum some of CSE topics (menstrual health) are included but our teachers skipped the chapter and said "please read the chapter at home." **– A 16-year-old unmarried adolescent girl, Rupnagar, Dhaka city**

SEXUAL AND REPRODUCTIVE HEALTH

In most cases, SRH is seen as only for married women, and mainly about reproduction, where maternal health and childcare are the primary content and can be discussed easily. For unmarried women, menstrual hygiene is the main component that can be discussed in terms of reproductive health care. Otherwise, it is seen as shameful to talk about. Even school is seen as an embarrassing environment to introduce sexual health education. On the other hand, parents think that unmarried people are not allowed to hear or discuss this and parents' lack of knowledge or even a basic understanding of SRH determines the extent of information that adolescents receive. And in the absence of prior SRH related knowledge, adolescents suffer from fear, depression, and anxiety when they experience rapid developments in their body due to biological changes.

"My mother thinks that if, as an unmarried adolescent girl, I have prior knowledge about sexual health it may lead me to become sexually active; this results in me not knowing about SRH, including not having enough information even about menstruation." **– A 14-year-old unmarried adolescent girl, Rupnagar, Dhaka city**

SEXUAL AND REPRODUCTIVE HEALTH PRACTICES

Only young men/boys/male members of the family usually access reproductive health services. Only in some special cases, like in maternal child-care services, women are allowed to go to clinics with their partner or in-laws, because men are considered good decision makers. Discriminatory care begins at the family level - male family members have priority to access any health services, girls don't have equal and accessible health rights because of family stigma and security. In most of the cases, adolescent girls have no idea about adolescent health service centers. Adolescent girls consider their mothers as their key source on SRH issues. Family members (mothers, sisters and mothers-in-law) appeared as the primary source of SRH information. This is because they have a trusting relationship with their family members.

"I don't know where the service center is and what amount of money is paid for the services because most of the time my husband and my mother-in -law go with me there and they pay the money."
– 19-year-old unmarried adolescent girl, Rupnagar, Dhaka city

Unmarried adolescent girls are highly restricted from accessing SRH related services. Most of the unmarried adolescent girls are not well educated about menstruation hygiene management (MHM). As a result, during their menstruation, they use cloth instead of sanitary pads. They all menstruate, though pronouncing this word is difficult for them. There are also myths around pregnancy and/or menstruation that restricts access or denies them nutritious food or vitamins.

"In Bangladesh, we felt comfortable using the phrase 'I am sick' during our menstrual cycle instead of 'I have a period". Most of the time, these restrictions prohibit us from going outside, even to school; entering the kitchen; touching any male; brushing their hair; and looking at the mirror. Some of them from rural areas believe that they should follow these restrictions." **– A 17-year-old unmarried adolescent girl, Rupnagar, Dhaka city**

SERVICES AT HEALTH CENTERS

Discriminatory care is prevalent in health centers. Only married adolescent girls are allowed to access SRH services, especially in the case of abortion, with no conditions attached. Unmarried adolescents have to fill in a checklist or obtain the signature of their guardians to access SRH services. Nurses, staff and medical doctors hold the same taboos and myths as the general society.

"I conceived at the age of 18. I was not prepared then to carry the unwanted child since I was working as a helping hand in many houses to earn for my family. So, I went to an old woman doctor and told my decision. But she suggested against the abortion because this is my first and said if I abort the child then it will be a mistake and it was possible that I may not conceive again. She told me that she always discouraged medical abortion due to complications, and in the hospital they don't give this service and they referred me to another clinic. The clinic finally suggested me to take one week for my final decision. This was a very embarrassing situation and confused me." **A 19-year-old married adolescent girl, Rupnagar, Dhaka city**

PRESENT SCENARIO

Most of the married adolescent girls face GBV when they take decisions related to health services on their own, especially without their husband's permission. And they cannot raise their voice against it. GBV is not a well understood concept in Bangladesh, and the health needs and rights of adolescent girls, particularly of unmarried adolescent girls, are inadequately addressed. Social norms and restrictions are a barrier which deprives adolescent girls of their access to information and their rights, leaving them unable to make informed reproductive health choices. In Bangladesh, adolescents and youth are particularly vulnerable to health risks, especially SRH. They have limited access to sex education. The information and services currently available are not enough, in particular for adolescents, and the quality of such information and services is often poor or inappropriate for the age group. During the COVID-19 pandemic, family planning services have been reduced or unavailable as well as a shortage of SRH commodities.

SUGGESTION FOR FUTURE ACTION

Conducting a survey is only a first step. Accessible services and comprehensive information must be provided to adolescents. There are many myths that need to be dispelled, such as no intake of any nutritious food or vitamins during pregnancy or menstruation. Discriminatory care and services at both hospitals and clinics are prevalent. These should be eliminated, including cultural taboos. In most of the cases from slum areas, adolescent girls use cloth rags instead of menstrual pad because of the availability and affordability. An awareness campaign on the importance of using SRH commodities is needed, with collaboration between government and NGOs. Age-appropriate sexuality education needs to be delivered in school, and both formal and non-formal settings. And school authorities and local governments need to be mobilized.

"In a lockdown situation for the pandemic, I faced many challenges. As a birth control method, I take injections every three months, but during the pandemic, the injection was unavailable in hospitals and clinics so I got worried." **– A 17-year-old married adolescent girl, Rupnagar, Dhaka city**

"We belong to poor income status, so it is very hard to buy a menstrual pad at a fixed high price. So the government should fix the rate of SRHR commodities at a low cost for availability in hands and if possible should be free of cost for poor status people." **– A 15-year-old married adolescent girl, Rupnagar, Dhaka city**

RECOMMENDATIONS

The following recommendations are made for consideration based on the study outcomes.

GENDER-BASED VIOLENCE

The observations through this pilot study have shown an urgent need to provide and improve access to youth-friendly SRH services that are confidential, non-judgmental, non-discriminatory, and affordable. SRH services and education must also include access to contraception, safe menstrual regulation, and prevention of reproductive cancer. Programmes need to be based on a human rights framework, including the right to be free from discrimination, sexual harassment, coercion and violence, as well as the principles of bodily integrity, dignity, equality, respect for diversity, and affirmative sexuality. Adolescents must be provided with safe spaces to discuss their needs and challenges including GBV and mental health.

SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

The majority of the respondents in this study have little information about SRHR, and not one of them had comprehensive information. Other than school, adolescent girls have received most of their information on SRHR from their family members, NGOs or community based organizations. The amount of information received from radio and television was very poor. The provision of information about SRHR through radio, television and other forms of media should be considered, so that adolescent girls can feel comfortable to talk about their relationships, health issues and rights.

COMPREHENSIVE SEXUALITY EDUCATION

CSE is mainly absent in the target population of this study. This limits their personal choices regarding SRH. The information that they are currently accessing is also not age appropriate.

Teachers, including the formal and non-formal (religious leaders and madrasa's teachers), should be provided training in CSE facilitation skills to address this. It is also important to introduce CSE for all young people through formal and informal channels, in community and workplace settings, in order to challenge gender norms, including harmful cultural norms and barriers such as child marriage, and misconceptions around puberty and menstruation.

CHILD MARRIAGE

Child marriage is a widespread issue in Bangladesh, and most of the adolescent girls in this study agreed that child marriage is an offence according to the Child Marriage Prevention Law, however, they still have little information about this law and what it constitutes. They will be unable to prevent it and stop the cycle if they cannot raise their voice about their own rights. Adolescent girls should be empowered and educated on the preventative steps. Awareness raising about prevention of child marriage also needs to be conducted for adolescents, parents and communities.

MENSTRUATION

In the context of Bangladesh, the taboo around menstrual health is still prevalent despite it being an issue of concern. These taboos emerge from an absence of awareness and management of menstrual hygiene, causing sensitive and painful complications. The adolescent girls in this study have very poor knowledge on this topic. The study reported that 54% of the respondents have little information about menstruation and seven (14%) respondents have no information about it and only 4% of the respondents have sufficient information on menstruation in general.

CONTRACEPTION

Ensuring access to and knowledge about modern contraception/family planning methods is very important for every woman and girl. But the study reported that 58% of the respondents have no information about contraception and 28% have little information. Around 40% adolescents reported the availability of contraceptives, reproductive health commodities, and menstrual pads in their community. Only 8% reported that oral pills are available, and 6% reported other contraceptives and reproductive health commodities are available in their community. Choice of modern methods of contraception is essential for protection from risks of HIV and other STDs. Providing more information can influence the access to methods of family planning among adolescent girls.

INTEREST IN ADDITIONAL INFORMATION ABOUT HIV, SRHR, CSE, CONTRACEPTION AND OTHER

The study reported that 86% of the adolescents would not like to know more about HIV, SRHR, CSE, contraception and other, and 52% of the respondents have no comment about additional information they wish to learn from school. The answer and ratio is surprising, but in the context of Bangladesh, it is very normal as young girls are not comfortable to talk about issues related to HIV, SRHR, and CSE with others.
They feel embarrassed and shy, and therefore, they want to avoid answering questions and/or have no interest to learn more about these topics. Adolescents would prefer to receive information in the future from family members, however stigma makes these 'shy matters' off limit for discussion between parents and their children. It is important to build awareness against these taboos prevalent in our community, and work to create healthy interest on these topics among adolescents.

URBAN HEALTH SERVICE CENTERS

The availability of youth services at UHSCs is challenging, especially during this unprecedented COVID-19 pandemic. This study revealed that a high percent of adolescents do not have a UHSC in their area and most do not have knowledge about them. Most do not even know in which area a UHSC is located, and whether it is near to their house. They also have no idea of the payment procedures when accessing these services. The government should prioritize setting up sufficient numbers of UHSCs and provide information to adolescents on how to access services. The study reported that 78% of the respondents had no idea whether UHSCs are friendly or not for young people, with only 6% of the respondents understood that UHSCs are friendly for young people. A further 84% of the respondents had no idea whether UHSCs are friendly for unmarried young people. And only a very few adolescents answered that they have service centers other than UHSC, the majority of adolescents do not know whether or not other service centers in their area are friendly to youth and unmarried people. These UHSCs must improve accessibility for young people in union, upazila and sub-divisional level with non-judgmental services. Operational plans including programmes and campaigns must be added on thematic topics to gain in-depth information and provide accurate services. There should also be a holistic approach implemented so that diversified young people of both married and unmarried in all levels get the priority to take the services in their affordability.

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ANNEX

KEY POINTS OF THE FOCUS GROUP DISCUSSIONS

Topics	Key opinion of the Discussants	Comments of the Moderator
1. Knowledge about CSE	• No formal/academic education • Some information included in madrasa curriculum • Got information from which they work in house • Knowledge gathered from family (mother-in-laws) • Misconception	• Knowledge acquired will help to demystify their notions about sexuality, and help them to deal with their own body and build confidence.
2. Sexual and Reproductive Health	• Married women have some information • Feel shy and embarrassed to talk • Embarrassing environment (introduction of SRH education in schools) • Lack of knowledge among parents (basic understanding of SRH)	• High priority should be given to increase awareness of parents and teachers on SRHR so that they can talk to their children and students without any embarrassment. • Reproductive, menstrual health and hygiene should be more detailed and comprehensive in the school curriculum.
3. Practices of Sexual Reproductive Health	• Decisions are taken by male members • Restrictions to unmarried girls • Discriminatory care towards adolescent girls • Acknowledge their family (mothers, sisters) as the primary source of service providers • No knowledge about service fees • Uses cloth during menstrual periods instead of sanitary pads • No idea about adolescent friendly health centers	• Empower the girls so they can make their own decision to enjoy their bodily rights. • Proper care should be given to boys and girls in the family and have no discriminatory care.

ANNEX

Topics	Key opinion of the Discussants	Comments of the Moderator
4. Services by Health Center	• Perception of taboo • Discriminatory services • Unmarried are inadequately addressed • Social norms and restrictions • Limited sex education related activities • Vulnerable to health risks • Inappropriate for the age group	• More information should be given to the government on friendly health centers. Use of radio, television, and social media could also be an effective strategy to provide information.
5. Present Scenario	• A survey is not enough • Provide correct information • Minimize cultural taboos • Minimize discriminatory care and services	• Properly address deprivation of unmarried adolescents in government policy and take steps to provide adequate sex education in both family and school spheres.
6. Suggestions for Future Action	• Provide enough SRHR commodities at low rate to make it affordable and available	• To improve their knowledge on reproductive health issues that lead to a healthy life. • Minimize the gap of knowledge and discriminatory care & services. • Formal, informal and special educational programs should be taken by the government to educate and address this gap.

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This mini-pilot was part of an APA initiative on building evidence for sexual and reproductive rights in Asia Pacific. The full report "Shifting the SRHR Narrative: The importance of CSO-generated evidence in Asia Pacific" is available on the APA website.

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