

ENDLINE EVALUATION OF ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH PROGRAM IN NASIRNAGAR 2008



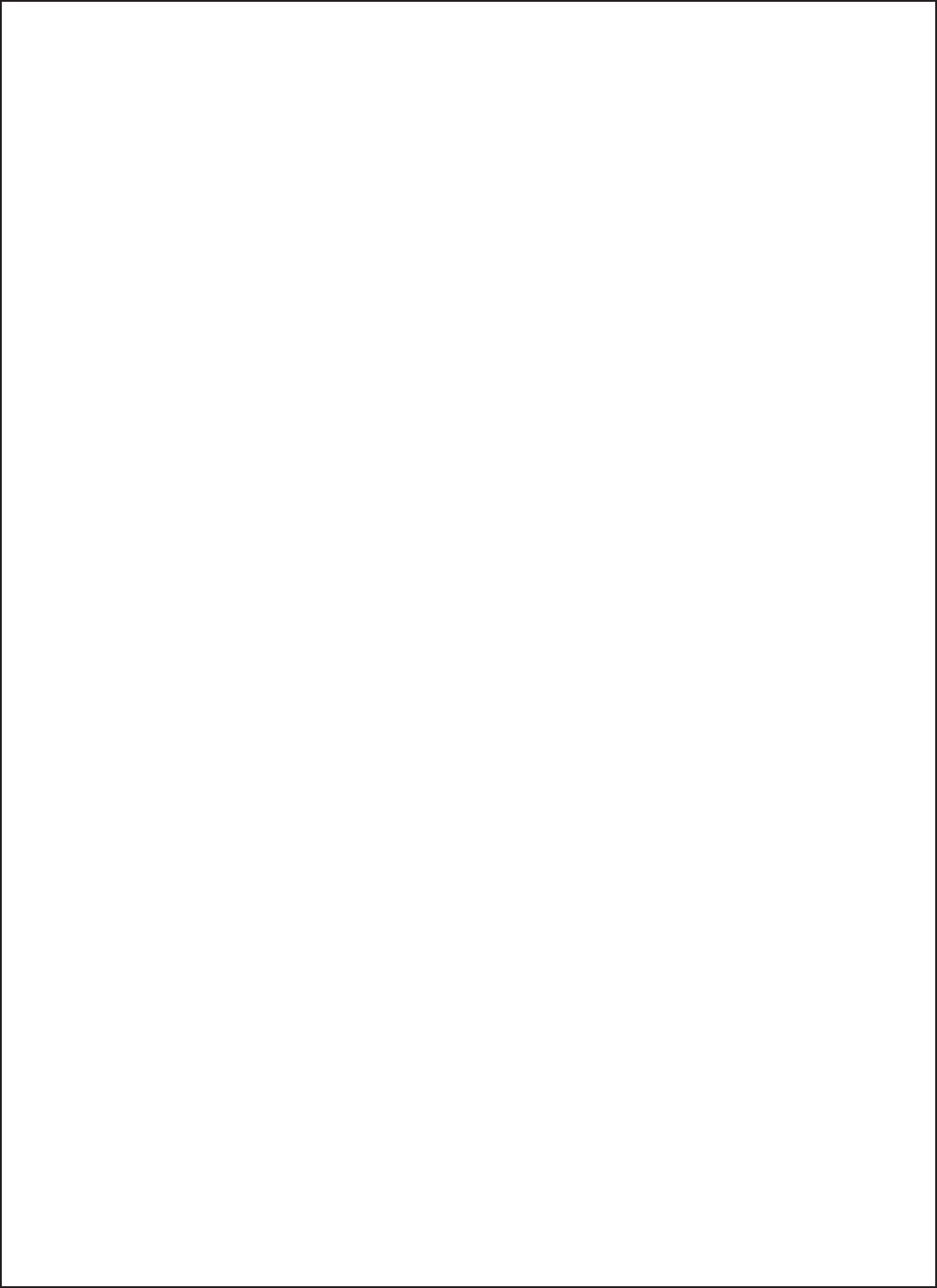
Save the Children



**Endline Evaluation of
Adolescent Reproductive
and Sexual Health Program in
Nasirnagar 2008**

November 2009

Save the Children USA
Bangladesh Country Office



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- Acknowledgement** : KAISHAR Program Staff of Nasirnagar
- Published** : November, 2009

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Acknowledgement

Adolescent Reproductive and Sexual Health (ARSH) Program of Save the Children USA tried to address adolescents' needs of Nasirnagar, Brahmanbaria by changing their behaviors through different interventions with interruptions during 2002/3-2008. This end line survey was done by Associates for Community and Population Research (ACPR) in 2008 among adolescents, parents and key community adults, to assess the difference with the baseline of 2004, to measure program results/ effects/ impacts in Nasirnagar sub-district. The results and recommendations can be utilized not only by Save the Children but also by the other organizations who are implementing adolescent programs in country and abroad.

Save the Children USA provided technical guidance and monitoring support to make this effort successful. Ministry of Health and Family Welfare continuously supported the interventions and evaluations. Adolescents, parents and community were the key and valuable contributors of this whole episode - starting from program initiation to phasing out who made this endeavor successful and graceful.

Glossary

ACPR	Associates for Community and Population Research
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARSH	Adolescent Reproductive and Sexual Health
BDHS	Bangladesh Demographic Health Survey
FP	Family Planning
HIV	Human Immunodeficiency Virus
MCWC	Maternal and Child Welfare Centre
PNC	Postnatal Care
RH	Reproductive Health
SC	Save the Children
STI	Sexually Transmitted Infections
TT	Tetanus Toxoid
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TFR	Total Fertility Rate
WHO	World Health Organization

Executive Summary

Introduction

Adolescence is a period of transition from childhood to adulthood. It is characterized by rapid physical, biological and hormonal changes resulting in to psychosocial, behavioral and sexual maturation between the 10-19 years in an individual. Adolescence is important because of the physical and mental changes and rapid developments of the adolescents from childhood to adulthood. During this period, the vulnerability related to health, especially reproductive and sexual health including HIV/AIDS, considerably increases among adolescents as they are poorly informed about those issues. They become exposed to the risks of malnutrition, disease, abuse, addiction, violence etc. those put them into problems, even disabilities and death. To address adolescents' needs of Nasirnagar, Brahmanbaria by changing their behaviors through different interventions, Save the Children USA implemented its Adolescent Reproductive and Sexual Health (ARSH) Program in Nasirnagar, Bangladesh from 2003 to 2008, in accordance with guidance from the Common Approach to Sponsorship Programs (CASP). This Endline results revealed following results regarding knowledge, attitudes and practices after five years of project implementation.

Knowledge and Supportive Environment

The ARSH program built the capacity of about 4,000 adolescents and 180 adults regarding

ARSH knowledge and skills, sensitized 50,000 parents and key adults in the community by disseminating ARSH information, conducted training for 340 health providers from government and non-government on adolescent-friendly health services, established and equipped 49 community-based adolescent information centers and school-based adolescent information corners. There were improvements in some areas compared to the baseline results such as adolescents' reproductive health related service utilization by about 6%, age at marriage by 0.8% for the girls and 0.4% for the boys, age at first child birth by 0.3%, age at first pregnancy by 0.4 %, contraceptive use by 5.7 %, condom use by 1.2%, knowledge about reproductive health by about 4% and attitude regarding mobility during menstruation by 6%, respectively.

Attitudes

99 % of parents of adolescent children affirmed their perspective that the adolescent boys and girls should have access to RH information and services. Parents also mentioned that they would allow their adolescent boys/girls to participate in the RH related programs. Attitudes from the community and religious leaders also changed, as they became more supportive for the project.

Note:¹ Adolescents' service utilization for reproductive health problems by about 6% (from 13.6% to 19.5%), age at marriage by 0.8% for the girls (from 14.6% to 15.4%) and 0.4% for the boys (from 15.2% to 15.6%), age at first child birth by 0.3% (from 15.6 % to 15.9%), age at first pregnancy by 0.4 % (from 15.3 to 15.7), contraceptive use by 5.7 % (from 17.9% to 23.6%), condom use by 1.2%, knowledge about reproductive health by about 4% and attitude regarding mobility during menstruation by 6% (from 43% to 48%),

Practices

Only 30% of the adolescents' parents discussed reproductive health issues with their adolescent children. Prior to the program, adolescents used to discuss about marriage with their sister-in-laws and brothers. The program helped delay the age of marriage from 14.6% to 15.4% and the age of the first pregnancy of adolescents from 15.3% to 15.7%. 47% of Adolescents participated in the ARSH program at endline compared to 9.2% at the beginning of the program Adolescents' involvement included discussion meetings, adolescent fairs, and adolescent education sessions.

Lessons learned

As part of the phase-out process, a lesson learned workshop took place in order to share and discuss the successes and lessons learned from the ARSH program in Nasirnagar. Resulting promising practices from that workshop have been used in the design of other adolescent focused projects in the country. Specific lessons that resulted from that workshop were:

- The consultation and involvement of local religious leaders during adolescent program implementation is critical for smooth implementation of the program.
- Involvement of representatives from local government health and family planning department, secondary education department and administrative department from the beginning of the program is fundamental for creating a supportive environment for the program.
- Awareness raising among parents, teachers and community leaders is also essential to improve their understanding of the program and to prevent any misunderstandings about the ARSH program.
- Programs should be contextualized according the local cultural norms and values, age and gender of the adolescents.
- The gap between formal and informal health service providers needs to be bridged to improve the referral services for adolescents.
- The incorporation of life skills and livelihood skills in training increases the participation of adolescents in the program.
- Problems, misunderstanding and conflicts should be urgently addressed for the continuation of the program.
- Capacity building of the peer educators in facilitating sessions and a program sustainability plan is necessary, so that the program activities will continue among peer groups after Save the Children leaves the area.
- Instilling community ownership of ARSH programs to the local community is vital for the sustainability of the program.
- Communicating, advocating, and engaging the religious leaders as key stakeholders should be done regularly throughout the program
- To address the gender sensitivity, education sessions should be separately held for boys and girls.
- Training curricula should be adapted according to the age of the participants and degree of cultural acceptance.

1

INTRODUCTION

1.1 Background

Adolescence is a challenging period during which boys and girls acquire life skills and knowledge and form habits that endure throughout their lives. This is the transition period from childhood to adulthood. In Bangladesh, young people, especially girls, reach adulthood with very little or preparation to ensure their reproductive and sexual health. In general, reproductive health knowledge among adolescents is low. The majority have no idea about the changes associated with puberty (e.g., menstruation or wet dreams) until they experience them. Their knowledge of symptoms, transmission and prevention of HIV/AIDS and other RTI/STDs is inadequate. In addition, adolescents tend to avoid seeking the help of health care providers for reproductive health problems. One tremendous obstacle young people face is the lack of accurate and accessible information regarding their reproductive and sexual health. Moreover, adolescents are often not linked to adolescent friendly sources of care, which, when combined with limited knowledge, hinders their ability to make informed choices to protect and promote their own well-being.

To assist adolescents in obtaining the knowledge and information need to successfully transition to healthy adulthood, Save the Children USA launched an adolescent reproductive and sexual health (ARSH) program, Named *KAISHAR*, in Nasirnagar (Brahmanbaria district) in 2004.

To monitor and evaluate the performance of the program, a baseline evaluation survey was conducted in the *KAISHAR* program areas of Nasirnagar in 2004. This report presents main results of a 2008 endline evaluation survey in the same areas, which examined changes/improvement on selected adolescent reproductive and sexual health (ARSH) indicators since the baseline.

1.2 The KAISHAR Program

The ARSH program, *KAISHAR* began its activities in all thirteen unions of Nasirnagar upazila, which falls under Brahmanbaria district, at the end of 2002. The overall goal of *KAISHAR* was to improve adolescents' reproductive and sexual health. The program sought to improve adolescents' help-seeking behavior and create an adolescent-friendly environment for provision of essential services. Through the program, Save the Children sought to expand adolescents' access to sources of reproductive and sexual health information and ensure they received support by linking them with existing services, as well as with informal sources of support such as peers, parents, and teachers. Save the Children adopted three key strategies for achieving these goals:

- To encourage adolescents to learn life skills and identify sources of information and assistance through participatory learning and action (PLA) sessions.
- To raise awareness on reproductive and sexual health issues among parents, shopkeepers, teachers and religious leaders, all of whom greatly influence young people's lives. Additionally, to improve communication between parents and their adolescent children. Save the Children designed and implemented existing and new community-wide communication strategies to disseminate reproductive and sexual health messages focusing on men taking more responsibility for family planning, reproductive/sexual health and childcare. A set of participatory tools were used to initiate discussion, dialogue, learning and behavior change of male family members. Later, Save the Children sought additional resources to scale up this program beyond Nasirnagar.

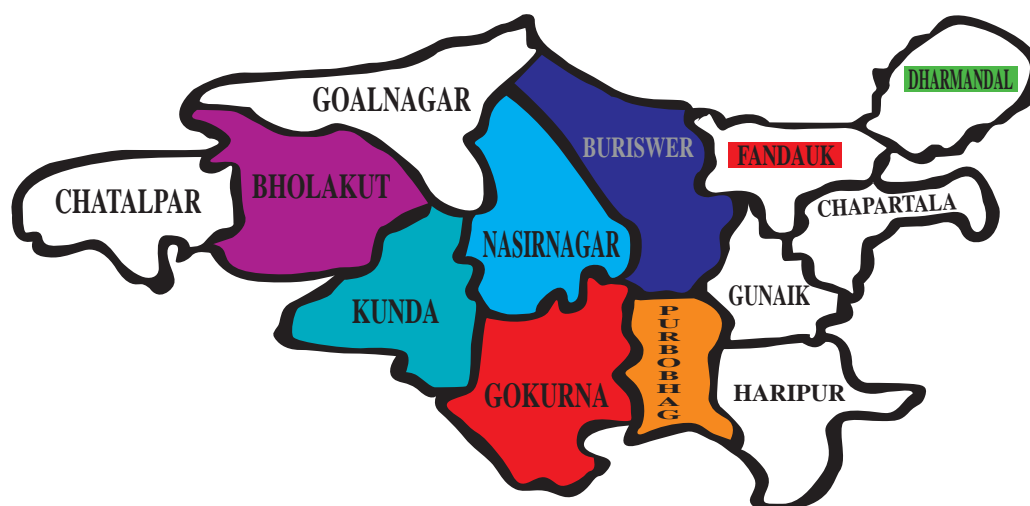
- To develop service provision for adolescents' RH through the HFS programs in the sponsorship area and also initiate dialogue and training among public and private health care providers on contraceptives and syndromic management of RTI/STDs.
- In addition, in response to the growing problems of the HIV/AIDS epidemic in this region, and in compliance with the Government's plan, Save the Children implemented a HIV/AIDS prevention strategy in the rural areas which promoted safer sexual behavior to reduce vulnerability.

Beginning in 2004, the *KAISHAR* program concentrated activities in six unions (Nasirnagar, Khulna, Burishwar, Gokorna, Bhdakut and Purbabagh). From 2005 through September 2006, following the *KAISHAR* model, a small Operations Research project, entitled the Young Motherhood Project, was implemented in an additional seven unions (Dharmondal, Chatalpar, Chaportala, Haripur, Fandauk, Guniok, and Goalnagar). In September 2007, Save the Children began the gradual phasing out of sponsorship programming in Nasirnagar and *KAISHAR* program activities were suspended in four unions (Kunda, Burshwar, Gokorna and Bholakut). The remaining two unions, Nasirnagar and Purbabagh, were phased out in September, 2008.

1.3 The Program Area

Nasirnagar upazila, the *KAISHAR* program area, is approximately 150 km northeast of Bangladesh's capital city Dhaka. It is one of the poorest and most underserved areas, with poorly developed infrastructure and few service facilities. The area consists mainly of low-lying marshy land which remains under water for five to six months in a year, dotted with islands where populations are clustered in crowded villages. The local mode of travel is mostly boat during the rainy season. In the dry season, people usually move on foot and need to cross numerous bamboo-bridges.

Save the Children worked in Nasrinagar area for more than 30 years and implemented various health and nutrition programs, including the *KAISHAR* program.



Nasirnagar consists of 13 unions with a total household population of approximately 2.84 million. Chatalpar and Gokurna have relatively high population concentration and Guniok has the lowest concentration. The average household size is approximately 5.6 (2004 baseline survey).

1.4 Objective of the survey

The overall objective of this survey was to assess current status of knowledge, attitude and practice related to reproductive and sexual health among adolescents (age 10-19) and measure changes on important ARSH indicators. The specific objectives were:

- To assess the knowledge, attitude and practice of adolescents in Nasirnagar about reproductive and sexual health
- To explore the lifestyle and life skills of adolescents, their sources of information/services, help seeking behavior, and existing social norms regarding RH, as well as their views about risk management and prevention.
- To measure changes in RSH knowledge, behavior attitude and practices of adolescents since the baseline survey in 2004.

2

METHODOLOGY

The endline KAISHAR evaluation survey intended to assess the current status of knowledge, attitude and practice among adolescents (aged 10-19) in Nasirnagar as they relate to reproductive and sexual health and life skills, and compare those with baseline estimates obtained in 2004. This chapter discusses methods of evaluation, description of samples, study implementation and limitations of the study.

2.1 Method

Since the aim of the evaluation was to provide insights into adolescents' sexual and reproductive health, the survey was based on representative samples of male-female and married-unmarried adolescents aged 10-19 years, selected from all the 13 unions of Nasirnagar. Additionally, parents of adolescent respondents were included in the survey. The survey was conducted using face to face interview techniques with sex-matched interviewers administering questionnaires.

2.1.1 Sample design and sample size

A stratified, two-stage cluster sampling method was used to select a representative sample of adolescents. Using the 2001 census framework of the Nasirnagar population, 60 clusters (a cluster being a village) were selected using systematic probability proportional to size (PPS) method. Starting from north-west corner of each selected cluster/village, households were visited to identify and interview eligible respondents (adolescents aged 10-19 by sex and marital status). Only one adolescent was interviewed from each household. The target was to interview five adolescents from each of four groups (unmarried male, married male, unmarried female, married female) of respondents in each selected cluster. Ultimately, 199 married male, 301 unmarried male, 301 married female and 299 unmarried female aged 10-19 were interviewed. Additionally, parents (an equal number of mothers and fathers) were also interviewed for some selected information.

2.2 Implementation of the study

The endline evaluation survey was initiated by Save the Children USA's Bangladesh Country Office and implemented by Associates for Community and Population Research, a Bangladeshi research organization located in Dhaka. A three-member research team headed by Prof. Dr. M. Sekander Hayat Khan was responsible for implementing the study. The other members of the team were Mr. A P M Shafiur Rahman and Ms. Tauhida Nasrin.

2.3 The survey instruments

Two instruments - a questionnaire for interviewing male and female adolescents and a household/parents questionnaire for interviewing parents/key adults - were used for the survey. The questionnaires were developed by ACPR research team in consultation with Save the Children. Most of the baseline questions were retained so that valid comparisons could be made with key baseline indicators. Questionnaires were pretested among parallel groups of respondents. Based on pretest results and consultation with Save the Children, the re-questionnaires were finalized. The questionnaires were developed in English and then translated and printed in Bangla.

As in the baseline survey, the endline adolescent questionnaire had six sections covering the following topics:

- ◆ Background characteristics such as age, religion, education and occupation;
- ◆ Information related to marriage, family planning and antenatal care;
- ◆ Information related to perception and attitude towards adolescent reproductive and sexual health issues;
- ◆ Knowledge of HIV/AIDS and sexually transmitted diseases;

- ◆ Utilization of health services, and
- ◆ Information related to awareness and participation in the KAISHAR program.

The household and parent questionnaire was used to collect some specific information related to the KAISHAR program. Questionnaires can be found in Appendix B.

2.4 Training, data collection, and quality control

The survey was conducted by deploying six teams, each consisting of 2 male interviewers, 2 female interviewers, a female supervisor, and a male supervisor. Team members were recruited from a pool of educated and experienced candidates and all held at least a graduation degree. Recruitment took place in mid-May 2008. Recruitment criteria included educational attainment and experience in other surveys of similar nature. Training for the survey staff was conducted from June 24 - July 1, 2008 at the ACPR training venue in Dhaka. The training included one day of field practice. Save the Children actively participated in the training process. Fieldwork commenced on July 2, 2008 and was completed on 13 July, 2008. Data collection was done by deploying five six-member teams, each consisting of one team leader, three female and two male interviewers. The target was to interview 1200 adolescents (300 unmarried and 300 married male and 300 married and 300 unmarried female age 10 - 19) from 60 selected clusters/villages. Ultimately, 199 married male, 301 unmarried male, 301 married female and 299 unmarried female could be successfully interviewed.

To ensure the quality of data collection, at the end of each days work the supervisors of each team thoroughly checked the completed questionnaires to ensure the consistency and completeness of information collected. ACPR also deployed three quality control teams to monitor the data collection process. The research team monitored the progress of work by keeping constant contact with the teams. A list of survey personnel is provided in Appendix C.

2.5 Data processing and analysis

All filled-in survey questionnaires were returned to the ACPR data processing cell in Dhaka for processing. The data processing operations consisted of office editing, data entry and editing for inconsistencies found by the computer programs. The data was processed on microcomputers using SPSS Software Program. Tables were prepared in accordance with an analysis plan developed by the PI and other research team members, based on the survey objectives. These were shared with Save the Children.

2.6 Limitations

Although all possible precautions were taken, some difficulties were encountered in conducting the study resulting in challenges and limitations in the desired analysis profile. Specifically,

- (i) Because of resource and time constraints, some compromise had to be made in the sample size. The married male sample was extremely small as only a few married male adolescents were available in the survey area.
- (ii) Nasirnagar households are not easily accessible. Continuous and excessive rains during the survey period made data collection difficult.
- (iii) All information were self-reported. As survey respondents were aware that Save the Children was conducting the survey, some respondents may have provided interviewers with information they believed the agency wanted to hear.
- (iv) As some of the indicators estimated based on small sample (and hence small sub sample), these should be interpreted with caution.

3

RESPONDENTS CHARACTERISTICS

This chapter presents information on selected characteristics of adolescents such as age, religion, education and occupation. This information is essential for interpretation of the survey findings and is useful for assessing changes in the status of reproductive health.

3.1 Characteristics of adolescents

Important findings on background characteristics of respondents are presented in Table 3.1. Table 3.1 shows the distribution of adolescents aged 10 to 19 years by selected background characteristics. The adolescent sample was selected by male-female and married-unmarried classifications from the age group 10-19. Among the male adolescents, 4.8 percent were in the age group 10-12 years, 16.6 percent were in the age group 13-15 years and the remainder (78.6 percent) were in age group 16-19 years. Among the female adolescents, slightly higher proportions came from the 13-15 years and 16-19 years age groups (25.7 and 68.2 percent respectively), while 6.2 percent were in the age range 10-12 years.

All the married male adolescents surveyed were in the age range 16-19, while among the married female adolescents 92.7 percent were in the age group 16-19 years and 7.3 percent belong to 13-15 years age group. The age distributions of unmarried male and female adolescents are similar.

Eighty four percent of the adolescent respondents were Muslims against 16 percent Hindus. Only 19 percent of male and female adolescents were currently attending school; almost all of the married males and females were out of school and a relatively higher proportion of unmarried females than unmarried males were attending school. The 2004 baseline survey reported similar results.

Nearly 16.2 percent of male and 17.3 percent of female adolescents had no education. The proportion of adolescents having no education is higher among married males (31.7 percent) as compared with married females (22.3 percent). This result suggests that the literacy rate has increased since 2004, when Save the Children's 2004 baseline survey estimated 29 percent of adolescents with no education (with an even higher rate among married adolescents: 52.3 percent for married males and 40.2 percent for married females).

Significantly, a much higher proportion of male adolescents (91.5 percent among married and 52.5 percent among unmarried) work for income, against less than 5 percent of female adolescents.

Except among those who were attending school, farming, trading and day labour were the main occupations of male adolescents, while household chore and farming were the main occupations of out of school female adolescents. The 2004 baseline survey also reported similar results.

Table-3.1: Characteristics of adolescents						
Percentage distribution of adolescents aged 10-19 years by background characteristics.						
Adolescents						
Characteristics	Male			Female		
	Married	Unmarried	All	Married	Unmarried	All
Age:						
10-12	-	8.0	4.8		12.4	6.2
13-15	-	27.6	16.6	7.3	44.1	25.7
16-19	100.0	64.5	78.6	92.7	43.5	68.2
Religion:						
Islam	88.4	82.1	84.6	84.4	81.3	82.8
Hinduism	11.6	17.9	15.4	15.3	18.7	17.0
Other	-	-	-	0.3	-	0.2
Education:						
No education	31.7	6.0	16.2	22.3	12.4	17.3
Primary	56.8	49.8	52.6	45.2	50.2	47.7
Secondary	11.6	41.5	29.6	32.6	36.1	34.3
Higher Secondary and above	-	2.7	1.6	-	1.3	0.7
Current schooling status:						
In School	-	29.9	18.0	1.3	39.8	20.5
Out of School	100.0	70.1	82.0	98.7	60.2	79.5
Working status:						
Working	91.5	52.5	68.0	3.7	8.0	5.8
Don't work	8.5	47.5	32.0	96.3	92.0	94.2
Occupation:						
Student	-	28.9	17.4	1.3	39.8	20.5
Housewife/ household chores	1.5	1.7	1.6	94.0	10.7	52.5
Skilled worker	8.5	8.0	8.2	0.7	3.3	2.0
Service	3.5	2.7	3.0	0.3	1.7	1.0
Trading	14.6	10.0	11.8	-	0.3	0.2
Shopkeeper	3.0	6.0	4.8	-	-	-
Farming	33.7	22.9	27.2	-	-	-
Boatman/tempo driver	5.5	1.7	3.2	-	-	-
Rickshaw puller	9.0	-	3.6	-	-	-
Day laborer	10.1	1.7	5.0	0.7	0.3	0.5
Cattle raising	-	1.0	0.6	0.3	0.3	0.3
Kitchen gardening	0.5	-	0.2	-	-	-
Fisherman	7.0	4.7	5.6	-	-	-
Tutionee	-	0.7	0.4	0.3	-	0.2
Nothing	3.0	10.3	7.4	2.3	43.5	22.8
N	199	301	500	301	299	600

4

ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

This section presents results related to the knowledge, attitude and practice of adolescents about reproductive and sexual health (ARSH). Results on the knowledge and perception of married and unmarried male-female adolescents on selected issues, including general perception of reproductive health (RH), reproductive health problems, physical changes during puberty, menstruation, attitude towards ARSH and utilization of RH care services are presented here.

4.1 Perception of reproductive health

In general, knowledge of reproductive health among adolescents is low in Bangladesh. Respondents were asked what is meant by reproductive health and what they consider as the major reproductive health problems. The same questions were also asked to an identical group of adolescents in the 2004 baseline survey. Table 4.1a gives the percentage of adolescents by perception of reproductive health, according to survey years. Table 4.1a shows that a significant proportion of male adolescents (23 percent of married and 9 percent of unmarried) have no idea about reproductive health. On the contrary, female adolescents (both married and unmarried) were found more aware of it. However, perception of RH was not precise and varied greatly by sex and marital status.

According to male adolescents, wet dream (38 percent of married vs. 61 percent of unmarried), physical changes of adolescents (49 percent of married vs. 61 percent of unmarried), marriage (33 percent of married vs. 23 percent of unmarried), mental change (17 percent of married vs. 43 percent of unmarried) and male and female reproductive organs comprise reproductive health.

According to female adolescents, reproductive health means menstruation (84 percent of married vs. 78 percent of unmarried), physical changes of adolescents (60 percent of married vs. 66 percent of unmarried), marriage (44 percent of married vs. 30 percent of unmarried), pregnancy (25 percent of married vs. 15 percent of unmarried), and mental changes of adolescents (23 percent of married vs. 30 percent of unmarried).

Awareness about reproductive health among adolescents seems to be little higher in 2008 compared with baseline time in 2004. The percentage with no knowledge, especially among females, has reduced significantly from 9 percent in 2004 to 1 percent in 2008 among married female and from 22 percent in 2004 to 5 percent in 2008 among unmarried female adolescents.

Table 4.1a Perception of reproductive health								
Percentage of adolescents by perception of reproductive health, according to survey years.								
Meaning of RH	Adolescents							
	Married male		Unmarried male		Married female		Unmarried female	
	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline
Physical changes of adolescent	49.2	11.5	60.5	25.3	60.1	64.6	65.6	61.5
Mental changes of adolescent	16.6	2.1	42.5	10.0	23.3	17.9	29.8	15.8
Reproductive organs of male	7.0	17.4	13.0	15.5	1.3	6.9	1.7	3.1
Reproductive organs of female	1.5	14.0	0.7	11.9	6.6	6.9	7.4	2.1
Function of reproductive organs	2.0	8.1	2.3	5.6	2.7	1.5	1.7	2.5
Menstruation	3.5	26.4	2.3	17.3	84.1	82.1	77.6	63.8
Wet dream	31.7	40.0	60.8	28.6	2.3	18.2	1.7	7.7
Process of child birth	5.5	11.1	2.0	7.3	4.7	2.9	5.4	1.0
Care of reproductive organs	0.5	1.7	1.0	1.3	0.7	1.4	0.3	1.0
Care of physical changes of adolescent	-	0.0	2.7	0.6	3.7	4.0	3.3	3.1
Care of mental changes of adolescent	-	0.9	0.3	0.2	1.0	0.4	-	1.0
Marriage	32.7	23.4	19.6	11.7	43.9	58.0	30.4	38.1
Pregnancy	6.5	24.3	2.7	10.7	24.6	47.1	14.7	29.0
Family Planning	0.5	0.9	1.3	2.1	1.3	10.9	1.0	3.3
To avoid different diseases of reproductive organs	0.5	0.0	2.7	1.3	0.3	0.4	0.3	0.4
To create harassment free environment/protect from harassment	-	0.0	-	0.4	-	4.7	0.3	4.2
About reproduction	7.0	14.0	2.0	6.0	0.7	3.3	-	2.3
Don't know	23.1	21.3	9.3	39.5	1.0	9.4	4.7	22.1
N	199	235	301	521	301	276	299	1512

4.2 Knowledge of reproductive health problems

Table 4.1b presents the percentage of adolescents by perception of RH problems. Levels of awareness about RH problems do not differ significantly among male and female adolescents. As perceived by male adolescents, wet dreams, itching in the genital area of men, pus from the penis and pain or burning sensation while passing urine are among the main reproductive health problems. A parallel set of problems were also identified as the RH problems by female adolescents. According to them, lower abdominal pain, irregular or painful menstruation, abnormal vaginal discharge and excessive bleeding are the common reproductive health problems that a girls/woman experience.

Lower abdominal pain and irregular/painful menstruation were the two major reproductive health problems as perceived by female adolescents (Figure 4.1). Wet dream is the most significant RH problem to male adolescents. The 2004 baseline survey also reported similar findings.

Table-4.1b: Perception of reproductive health problems								
Percentage of adolescents by perception of reproductive health problems, according to survey years.								
RH Problems	Adolescents							
	Married male		Unmarried male		Married female		Unmarried female	
	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline
Irregular/painful menstruation	8.0	20.0	4.3	12.1	55.1	50.0	48.8	32.7
Abnormal vaginal discharge	1.0	2.6	-	1.0	22.3	12.0	16.1	5.4
Lower abdominal pain	4.5	5.1	0.7	2.5	84.7	59.4	73.9	51.7
Excessive bleeding	-	4.3	0.3	2.9	15.3	24.3	14.0	16.3
Foul smell of the menstrual blood	-	13.2	-	9.6	4.0	4.0	4.0	2.1
Itching in genital area(Boy)	13.1	12.8	38.9	12.9	-	6.5	0.3	2.3
Itching in genital area(girl)	1.0	3.4	1.3	4.6	4.0	10.1	3.0	5.6
ANC	5.0	14.9	10.0	12.5	19.9	43.8	6.0	20.0
Delivery	1.5	11.1	5.0	7.3	7.0	32.2	3.0	20.6
PNC	-	2.1	3.0	1.5	1.7	4.0	0.7	1.3
Wet dream	47.7	61.7	64.6	44.1	1.0	14.5	2.0	6.0
Contraceptive/Family Planning	1.5	0.0	0.3	0.4	0.3	3.6	0.3	0.6
Pain/burning sensation passing urine	11.1	2.1	17.9	3.8	1.0	6.2	0.3	2.9
Syphilis	0.5	1.3	5.3	1.0	-	0.7	-	0.4
Pus from penis	13.1	10.6	17.6	10.4	3.3	9.8	1.3	5.8
Infertility	5.0	4.3	2.3	2.5	1.0	5.1	1.0	1.0
Penile discharge	4.5	8.9	6.6	3.5	0.3	0.0	-	0.2
Don't know	32.2	17.4	12.3	38.6	2.7	10.9	9.7	31.9
N	199	235	301	521	301	276	299	1512

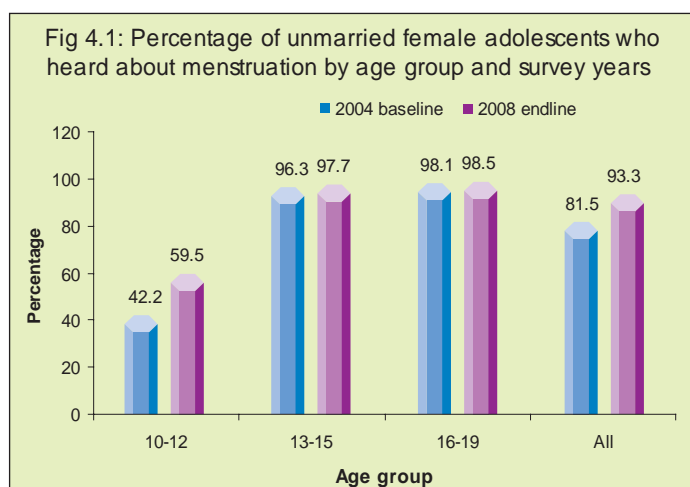
4.3 Knowledge of sources of RH care services

Respondents were asked about the sources from where reproductive health care services can be obtained. Table 4.1c shows that about 13 percent of married males, 7 percent of unmarried males, 3 percent of married females and 7 percent of unmarried females are not aware of any source. The commonly known sources were: upazila health complex (49 percent), private clinic/MBBS doctors (30 percent), district hospitals (28 percent), and village/traditional doctors (20 percent).

Table-4.1c: Knowledge of sources of RH Care/ Services								
Percentage of adolescents by knowledge of sources of RH care/ services, according to survey years.								
Sources of RH care/ services	2008 endline survey				2004 baseline survey			
	Married male	Unmarried male	Married female	Unmarried female	Married male	Unmarried male	Married female	Unmarried female
PUBLIC SECTOR								
District Hospital	20.6	10.6	17.9	11.4	34.9	28.2	30.8	27.9
Family welfare centre	8.5	11.6	12.6	9.4	17.4	15.0	8.7	9.0
Upazila health complex	46.7	48.8	49.2	42.5	51.9	48.9	57.6	49.4
MCWC	-	-	0.3	-	0.4	1.0	-	0.4
Rural dispensary/Community clinic	-	0.7	1.7	2.7	0.9	0.4	-	0.6
Satellite clinic/EPI outreach site	-	-	6.6	6.7	0.9	0.8	2.2	1.3
Govt. field worker	1.0	4.3	4.3	4.3	0.9	1.7	2.2	1.9
NGO SECTOR								
Static Clinic	2.5	4.7	1.7	2.3	2.1	4.2	3.3	2.9
Satellite clinic	9.5	1.3	0.7	1.3	2.1	1.3	0.7	0.4
Fieldworker	4.0	3.7	4.3	3.0	0.4	1.7	0.4	-
Depotholder	2.5	1.7	1.0	0.7	-	-	0.4	0.2
PRIVATE SECTOR								
Private clinic/MBBS doctor	15.1	9.6	12.3	9.7	19.6	16.9	36.6	30.0
Village doctor/Traditional doctor	36.7	33.6	19.9	21.1	24.7	21.9	25.4	20.4
Pharmacy	47.7	31.6	26.2	30.1	4.3	4.0	5.1	4.6
SAVE THE CHILDREN USA								
KAISHAR program					2.6	5.4	1.4	3.3
Information centre	-	0.3	-	-	-	-	-	-
Information corner	1.0	2.0	0.3	1.0	-	-	-	-
Radio/TV	-	0.7	-	1.0	-	-	-	-
News paper/magazine	-	-	-	-	-	0.2	-	-
Other	-	-	-	-	2.6	0.2	0.7	-
Don't know	13.1	7.0	2.7	7.0	7.7	13.8	3.3	11.7
N	199	301	301	299	235	521	276	480

4.4 Knowledge of menstruation

Lack of prior knowledge about menstruation could result in severe mental tension for the girls who experience menarche for the first time. It is therefore beneficial if adolescent girls know about menstruation before its onset. The survey found that knowledge of menstruation among unmarried female varied by age; about 98.5 percent of age 16-19 heard about menstruation, against 59.5 percent of age 10-12 and 97.7 percent of age 13-15. Knowledge of menstruation by survey years is given in Figure 4.1. In 2008, 93 percent of unmarried female adolescents aged 10-19 had heard about menstruation vs. 82 percent in the baseline in 2004 (Figure 4.1).



Awareness of menstruation has increased by 17 percentage points among females aged 10-12 from 42.2 percent in 2004 to 59.5 percent in 2008 (Table 4.2a).

About 40 percent of adolescents (against 34 percent at baseline) believe that food restriction is required during menstruation and 48 percent (against 43 percent at baseline) are of the opinion that menstruating girls can move freely anywhere either in school or in the community without any fear.

About 90 percent of female adolescents feel comfortable to talk about menstruation with someone; the corresponding figure was 78 percent in 2004. The persons with whom they feel free to talk about menstruation are mother (33 percent), sister-in-law (32 percent), sister (29 percent) and friends (12 percent).

A higher proportion of young adolescents aged 10-12 reported that they were comfortable talking with someone about menstruation in 2008 (77 percent) than in 2004 (47 percent).

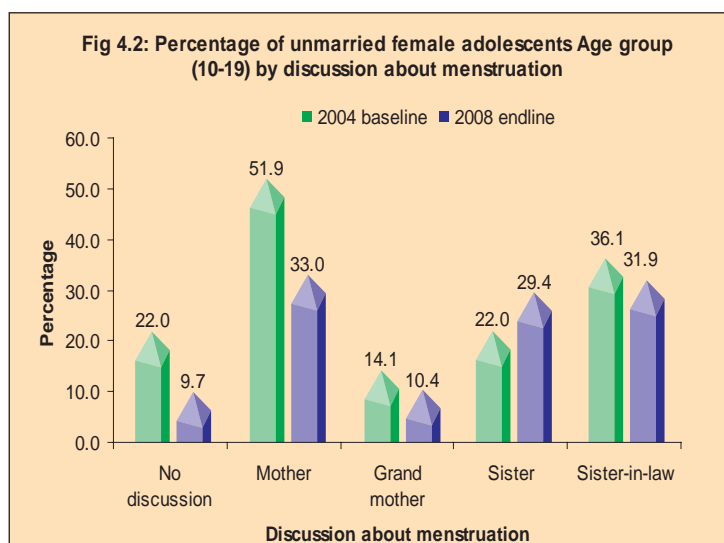


Table 4.2a: Awareness of menstruation among unmarried female adolescents

Percent distribution of unmarried female adolescents by awareness and attitude about menstruation, according to survey years.

Awareness/attitude	Age group						All	
	10-12		13-15		16-19		Endline	Baseline
	Endline	Baseline	Endline	Baseline	Endline	Baseline		
Heard about menstruation:								
Yes	59.5	42.2	97.7	96.3	98.5	98.1	93.3	81.5
No	40.5	57.8	2.3	3.7	1.5	1.9	6.7	18.5
N	37	135	132	241	130	104	299	480
Persons with whom feel free to talk about menstruation:*								
None	22.7	52.6	8.5	20.3	8.6	8.8	9.7	22.0
Mother	45.5	35.1	27.9	53.4	35.9	57.8	33.0	51.9
Grand mother	4.5	10.5	7.0	15.1	14.8	13.7	10.4	14.1
Sister	27.3	10.5	32.6	22.4	26.6	27.5	29.4	22.0
Sister in law	9.1	12.3	29.5	34.1	38.3	53.9	31.9	36.1
Aunt	4.5	7.0	8.5	4.3	5.5	6.9	6.8	5.4
Friends	13.6	-	12.4	-	11.7	-	12.2	-
Others	-	-	2.3	-	0.8	-	1.4	-
Whether food restriction is required for menstruating girls:								
Yes	18.2	29.8	44.2	32.8	39.8	39.2	40.1	34.0
No	45.5	50.9	51.9	64.2	57.0	59.8	53.8	61.1
Don't know	36.4	19.3	3.9	3.0	3.1	1.0	6.1	4.9
Whether a menstruating girl can move freely:								
Yes	40.9	43.9	55.0	44.0	41.4	40.2	47.7	43.2
No	36.4	42.1	43.4	53.4	57.0	59.8	49.1	53.2
Don't know	22.7	14.0	1.6	2.6	1.6	-	3.2	3.6
N	22	57	129	232	128	104	279	391

* Multiple responses

4.5 Awareness of physical changes of boys during puberty

Unmarried male adolescents were asked if they were aware of pubertal changes that a boy experiences during adolescence. A majority of the adolescent boys were able to mention one or more physical signs of puberty. The signs that they mentioned include: frequent wet dreams growth in different parts of body, starting of ejaculation, voice change, widening of chest and shoulders, external genital development and appearance of acne (Figure 4.2). Awareness is positively associated with age and the elder group of male adolescents have higher knowledge about key physical changes. Overall, 86 percent of male adolescents could mention at least two signs of physical changes among boys (only 44 percent of boys aged 10-12).

Knowledge of adolescent boys about at least two pubertal changes has increased by 22 percentage points from 64 percent in 2004 to 88 percent in 2008.

Adolescent boys were asked with whom they feel free to talk about wet dreams. About 41 percent do not feel free to talk about wet dream with any

one. Those who reported to feel free to discuss about wet dreams with someone, cited friends, sister/brother-in-laws, and brothers (Table 4.2b). The 2004 baseline survey did not collect this information.

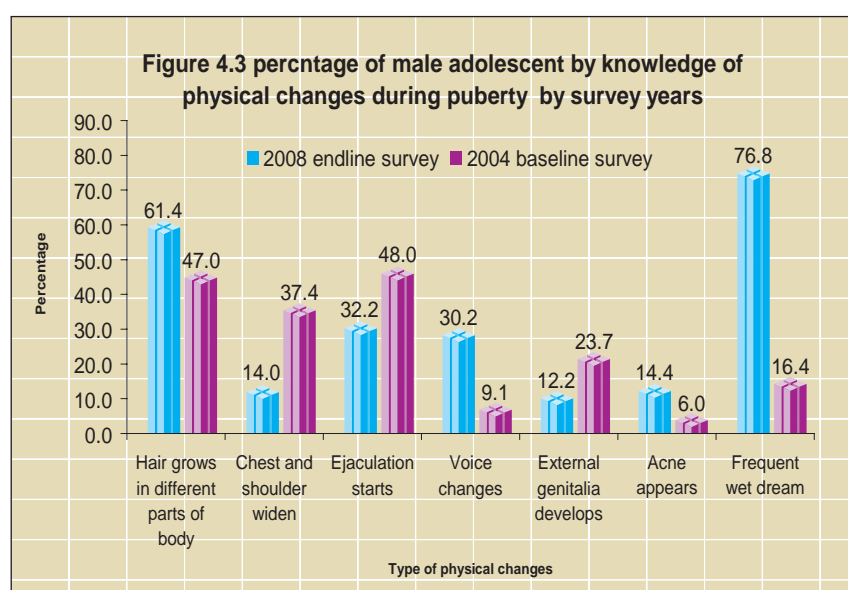


Table 4.2b: Awareness of physical changes among adolescent boys

Percentage of unmarried male adolescents by perception about physical changes during adolescence by age, according to survey years.

Perception	Percentage by age group						Survey year	
	10-12		13-15		16-19		2008	2004
	Endline	Baseline	Endline	Baseline	Endline	Baseline		
Types of physical changes that a boy experience:								
Hair grows in different parts of body	29.2	45.0	66.7	47.9	62.2	47.1	61.4	47.0
Chest and shoulder widen	-	42.0	15.5	39.1	14.5	35.5	14.0	37.4
Ejaculation starts	41.7	11.5	38.1	37.9	30.4	62.3	32.2	48.0
Voice changes	50.0	7.6	40.5	10.1	26.8	9.2	30.2	9.1
External genitalia develops	8.3	17.6	8.3	26.0	13.3	24.6	12.2	23.7
Acne appears	4.2	5.3	16.7	5.9	14.5	6.1	14.4	6.0
Frequent wet dream	54.2	1.5	70.2	14.8	79.6	21.3	76.8	16.4
Others	-	-	-	-	0.3	-	0.2	-
Don't know	16.7	31.3	3.6	16.6	1.5	9.0	2.6	14.6
Knows at least two changes	66.7	45.0	88.1	61.5	86.7	70.2	86.0	63.9
Knows at least three changes	33.3	16.0	53.3	24.9	43.8	34.2	44.8	29.0
N	24	131	84	169	392	456	500	756

Table 4.2c: Discussion about wet dreams				
Percentage of unmarried male adolescents by discussion about wet dreams by age.				
Perception	Percentage by age group			
	10-12	13-15	16-19	All
Persons with whom feel free to talk about wet dream				
None	83.3	46.4	37.5	41.2
Mother	4.2	4.8	3.3	3.6
Father	-	3.6	1.3	1.6
Grand mother	-	4.8	3.8	3.8
Grand father	-	7.1	2.0	2.8
Brother	-	14.3	13.3	12.8
Sister/ brother in law	8.3	17.9	24.5	22.6
Uncle	-	2.4	1.5	1.6
Friends	4.2	22.6	31.9	29.0
Others	-	1.2	2.0	1.8
N	24	84	392	500

4.6 Discussion about own marriage and partner

Unmarried male and female adolescents aged 15-19 years were asked with whom they are easily able to talk about their own marriage and partner. About discussion regarding their own marriage, adolescents reportedly finding it easy to talk mostly with sister-in-laws/brother-in-laws (48 percent), parents (21 percent), sisters/brothers (20 percent) and friends (17 percent). Adolescent girls are less likely to discuss this than are adolescent boys. About 25 percent of unmarried female against 12 percent of males do not feel free to discuss their own marriage with anyone (Table 4.3).

As regards discussion about their own partners, females are less likely to discuss with anyone than males. In-laws, friends and sisters/brothers are the main people with whom they feel free to discuss about their own partners. These findings are similar to those as recorded in the baseline report of 2004.

4.7 Discussion about RH issues

Both male and female adolescents were asked whether they discuss RH matters other than marriage, wet dream and menstruation with their parents. They were also asked about reasons for discussion if they discuss, and reasons for not discussion if they do not discuss. Table 4.3a shows that 29 percent of adolescents discuss RH issues with parents. The main reasons for discussion as cited by those who discuss were to avoid illness, not to face any problem, don't know much about RH, will take to doctors for care and it is better to discuss this with parents. Those who do not discuss mentioned the following reasons for not discussion: feel shy to discuss RH issues, do not consider necessary, do not feel easy/afraid and because parents may think negatively about me.

Table 4.3: Discussion of marriage and partner

Percentage distribution of unmarried adolescents age above 15 years by persons with whom they feel free to talk about own marriage and partner, according to survey years.

	2008 endline survey			2004 baseline survey		
	Male	Female	All	Male	Female	All
Persons with whom find easy to talk about own marriage:						
Parents	24.2	16.9	21.3	23.0	30.1	26.6
Grand mother	10.3	14.6	12.0	37.4	31.1	34.3
Grand father	8.2	-	4.9	33.3	5.8	19.6
Sister/brother	19.1	22.3	20.4	22.1	26.2	24.2
Sister/brother in law	51.5	42.3	47.8	69.4	64.1	66.8
Aunt	0.5	4.6	2.2	5.4	4.9	5.2
Uncle	3.1	-	1.9	5.4	1.0	3.2
Friends	19.1	13.8	17.0	-	-	-
Others	2.6	-	1.5	-	-	-
Nobody	11.9	24.6	17.0	2.3	19.4	10.9
Persons with whom find easy to talk about own partner:						
Parents	16.5	7.7	13.0	12.2	19.4	15.8
Grand mother	5.2	15.4	9.3	30.6	19.4	25.0
Grand father	5.2	-	3.1	24.8	1.9	13.4
Sister/brother	21.6	24.6	22.8	19.8	29.1	24.5
Sister/brother in law	52.6	33.1	44.8	67.6	61.2	64.4
Aunt	1.5	4.6	2.8	4.5	6.8	5.7
Uncle	1.5	-	0.9	5.4	0.0	2.7
Friends	28.4	15.4	23.1	-	-	-
Others	1.5	-	0.9	-	-	-
Nobody	9.8	25.4	16.0	4.1	30.4	12.3
N	194	130	324	222	103	325

Table 4.3a: Discussion about others RH issues								
Percent distribution of adolescents by discussion with parents about others RH issues (except marriage, menstruation, wet-dream) by age group								
	Male				Female			
	10-12	13-15	16-19	All	10-12	13-15	16-19	All
Whether discuss other RSH issues (except marriage, menstruation, wet-dream) with your parents								
Yes	20.8	14.5	12.5	13.2	29.7	20.1	32.8	29.3
No	79.2	85.5	87.5	86.8	70.3	79.9	67.2	70.7
N	24	83	393	500	37	154	409	600
Reasons for discussion with parents about other RH issues:								
Don t know much about RH	-	8.3	14.3	12.1	72.7	29.0	17.9	23.3
Discuss with mother as I am not able to conceive	-	8.3	6.1	6.1	-	3.2	7.5	6.3
It is better to discuss these with parents	-	-	12.2	9.1	-	6.5	9.7	8.5
To avoid illness	80.0	25.0	26.5		27.3	22.6	25.4	25.0
Discuss with parents if face any problem	-	8.3	18.4	15.2	9.1	25.8	25.4	24.4
Mother will take me to doctors if discuss with her	20.0	41.7	22.4	25.8	9.1	19.4	11.9	13.1
Others	-	16.7	10.2	10.6	-	-	7.5	5.7
N	5	12	49	66	11	31	134	176
Reasons for not discussion with parents about other RH issues:								
Feel shy to discuss other RH issues	73.7	82.9	85.2	84.6	80.8	85.4	86.9	86.1
Parents may think that I am spoiled	10.5	5.6	7.0	6.9	3.8	1.6	5.1	4.0
Do not feel easy/afraid	15.8	9.9	11.3	11.3	7.7	4.1	7.3	6.4
Parents do not like	-	1.4	0.9	0.9	-	0.0	5.1	3.5
Parents do not understand these	10.5	1.4	0.6	1.2	-	1.6	1.1	1.2
Do not consider necessary	5.3	5.6	3.5	3.9	11.5	10.6	7.3	8.5
Other	-	-	2.3	1.8	-	0.8	0.7	0.7
N	19	71	344	434	26	123	275	424

4.8 Age at marriage, first pregnancy and child birth

One of the demographic indicators which has the greatest significance in the lives of adolescents, particularly of girls, is marital status. In Bangladesh, despite a gradual upward trend, girls still get married at an extremely young age. Girls are considered eligible for marriage as soon as they show signs of adolescent growth. The search for husbands starts around the onset of menstruation for many girls and may even result in marriage before menarche.

The survey gathered information from married adolescents on the actual age of girls at first marriage, actual age at first pregnancy and actual age at first the birth of their first child. A married girl was asked about her age at marriage and a married male was asked about the age of his wife at marriage. A female adolescent who had given birth or was currently pregnant was also asked to state her age at the onset of pregnancy and childbirth. The same set of questions was also asked to each married male adolescent about the age at pregnancy and age at childbirth of his wife.

Table 4.4a shows that the actual mean age at marriage, age at first pregnancy and age at first child birth, as reported by married girls is 15.4 years, 15.7 years, and 15.9 years respectively, which are slightly higher than the baseline estimates. The estimates obtained from responses provided by male on these issues are not significantly different from which were reported by females.

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Table 4.4a: Age at first marriage and age at first childbirth				
Percent distribution of adolescents by their actual age at marriage, actual age at first pregnancy and childbirth, according to survey years.				
Perception and Practice	Respondents			
	2008 endline survey		2004 baseline survey	
	Male	Female	Male	Female
Actual age at marriage (in years):				
10-12	0.5	4.0	6.0	1.8
13-15	50.3	50.8	49.6	72.1
16-19	49.2	45.2	44.4	26.1
Mean age	15.6	15.4	15.2	14.6
N	199	301	235	276
Actual age (in years) at first pregnancy:				
10-12	0.9	1.4	-	0.5
13-15	31.0	47.0	41.7	55.3
16-19	68.1	51.6	58.3	44.2
Mean age	16.0	15.7	15.7	15.3
N	116	215	132	190
Actual age (in years) at first birth:				
< 13	-	0.6	-	2.3
13-15	18.7	40.5	32.9	44.2
16-19	81.3	58.9.	67.1	53.5
Mean	16.3	15.9	16.1	15.6
N	75	173	76	129

4.8.1 Age Differentials in sponsored vs non-sponsored areas

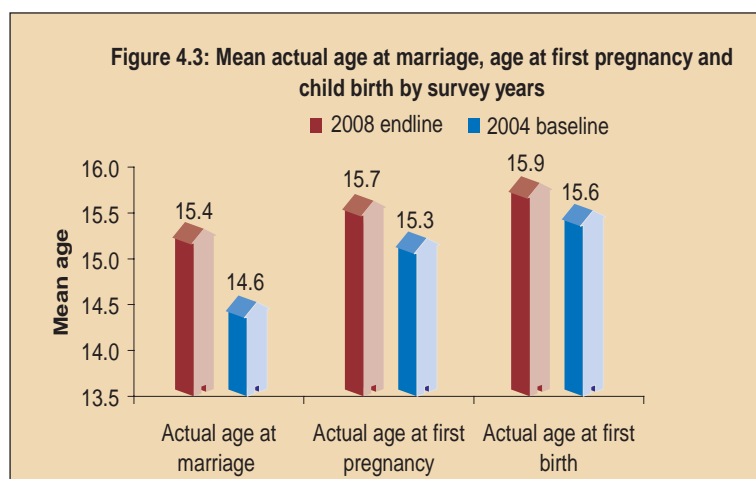
It may be mentioned that KAISHAR Program started in all 13 unions of Nasirnagar in 2003, and then concentrated into 6 unions (called sponsored unions- Bholakut, Barishwar, Gokarna, Kunda, Nasirnagar, and Purbabag) since 2004. In the other 7 non-sponsored unions, program for adolescent girls continued from 2005 to September, 2006 and then phased out. The first four sponsored unions were phased out from the program in September, 2007 and the program continued only in two unions, namely Nasirnagar and Purbabagh. From programmatic point of view, it would be interesting to see if significant differences exist between sponsored and non-sponsored areas on important RSH indicators.

Table 4.4b gives age at marriage, age at first pregnancy and age at first childbirth by sponsored and non-sponsored unions. Table 4.4b shows that age at marriage, age at first pregnancy and age at first childbirth are not different in sponsored and non-sponsored unions.

Table 4.4b: Age differential by sponsored vs non-sponsored areas						
Percent distribution of adolescents by their actual age at marriage, actual age at first pregnancy, and actual age at first childbirth, according to sponsored and non-sponsored unions.						
	Sponsored unions			Non sponsored unions		
	Male	Female	All	Male	Female	All
Actual age at marriage (in years):						
10-12	-	5.3	3.1	1.1	2.7	2.1
13-15	51.9	57.6	55.2	48.4	44.0	45.6
16-19	48.1	37.1	41.7	50.5	53.3	52.3
Mean age	15.5	15.1	15.2	15.6	15.7	15.7
N	108	151	259	91	150	241
Actual age (in years) at first pregnancy:						
10-12	-	0.8	0.5	2.0	2.1	2.1
13-15	34.3	51.7	45.4	26.5	41.2	36.3
16-19	65.7	47.5	54.1	71.4	56.7	61.6
Mean age	16.0	15.6	15.8	16.0	15.7	15.8
N	67	118	185	49	97	146
Actual age (in years) at first birth:						
< 13	-	1.0	0.7	-	-	-
13-15	20.0	38.4	32.6	16.7	43.2	35.6
16-19	80.0	60.6	66.7	83.3	56.8	64.4
Mean	16.3	15.9	16.0	16.3	15.9	16.0
N	45	99	144	30	74	104

4.9 Use of contraception

Studies in both developing and developed countries demonstrate that the behavioral pattern of contraceptive acceptance and use differs significantly between adolescents and adults (United Nations, 1999). Widespread family planning practices among adolescents is crucial for the reduction of total fertility rate (TFR), which showed a slight decline recently after having remained stagnant for about a decade in Bangladesh.



Current use of contraception is defined as the proportion of currently married females who are using a family planning method, either modern or traditional, at the time of interview. Modern FP methods include contraceptive pills, IUDs, injectable contraceptives, condoms, male and female sterilization and norplant/implant. Traditional methods include periodic abstinence, withdrawal and rhythm method. Married female adolescents were asked whether they currently use any method to avoid having children. The same question was also asked to married male adolescents. Table 4.4b shows the percentage of currently married male and female adolescents aged 13-19 years by reported current use of contraception methods with method mix, according to selected background characteristics.

Overall, 23.6 percent of currently married females and 26.3 percent of currently married males reported using any contraceptive methods (Table 4.5 & Figure 4.6). Modern methods are much preferred (22.3 percent) to traditional methods (1.4 percent). Among the modern methods, contraceptive pills (14.7 percent) are the most popular method of contraception, followed by contraceptive injections (3.8 percent), and condoms (2.7 percent).

Current use of contraception varied considerably by age. Current reported use was higher among female adolescents aged 16-19 years. Use of a family planning method is directly associated with the level of education attained by married females; young women with a secondary level of education are almost two times (30.9 percent) more likely to use a family planning method than those who have no education (15.6 percent).

Reported use of any FP method among female adolescent increased by 5.7 percentage points from 17.9 percent in 2004 to 23.6 percent in 2008. The percentage increase in the use of modern methods is 10.1 percent and 8.8 percent increase was noted in the use of pill.

The prevalence of contraceptive use among married female adolescents in Nasiragar is found to be substantially lower (23.6 percent) than the national use rate among the comparable groups (38.1 percent, BDHS 2007).

4.9.1 Use of FP methods in sponsored vs. non-sponsored unions

Table 4.5b gives the percent distribution of currently married female adolescents by current reported use of FP methods, according to sponsored and non-sponsored unions. The use rates are

presented by age and educational level of respondents. Table 4.5b shows that use of any family planning method and use of any modern FP method is reported to be significantly higher in sponsored union areas than non-sponsored areas. Use of any method in sponsored areas is 25 percent against only 14 percent in non-sponsored areas.

Table 4.5: Current use of contraception by background characteristics										
Percent distribution of currently married female adolescents by reported contraceptive method currently used, according to selected background characteristics										
Characteristics	Using any method	Using any modern method	Modern method					Traditional method (safe period)	Not currently using	N
			Pill	Condom	Inj.	Norplant /Implant	Fem. sterilization			
Female Respondents										
Respondents' age:										
13-15	15.0	15.0	5.0	10.0	-	-	-	-	85.0	20
16-19	24.3	22.8	15.4	2.2	4.0	1.1	-	1.4	75.7	272
Highest education level:										
No Education	15.6	15.6	4.7	3.1	7.8	-	-	-	84.4	64
Primary	22.1	20.6	16.0	2.3	0.8	1.5	-	1.5	77.9	131
Secondary +	30.9	28.9	19.6	3.1	5.2	1.0	-	2.1	69.1	97
All	23.6	22.3	14.7	2.7	3.8	1.0	-	1.4	76.4	292
Male Respondents										
Respondents' age:										
13-15	-	-	-	-	-	-	-	-	-	-
16-19	26.3	25.3	14.2	7.9	2.1	0.5	0.5	1.1	73.7	190
Highest education level:										
No Education	22.6	22.6	14.5	4.8	1.6	1.6	-	-	77.4	62
Primary	26.7	25.7	14.3	7.6	2.9	-	1.0	1.0	73.3	105
Secondary +	34.8	30.4	13.0	17.4	-	-	-	4.3	65.2	23
All	26.3	25.3	14.2	7.9	2.1	0.5	0.5	1.1	73.7	190

Table 4.5a: Use of contraception by survey years						
Percent distribution of currently married female adolescents by reported use of any FP method and modern method, according to survey years						
Background characteristics	2008 endline survey			2004 baseline survey		
	Using any method	Using any modern method	N	Using any method	Using any modern method	N
Respondents' age:						
13-15	15.0	15.0	20	16.1	16.1	62
16-19	24.3	22.8	472	18.5	12.3	211
Highest education level:						
No Education	15.6	15.6	64	17.4	10.1	109
Primary	22.1	20.6	131	14.1	10.1	99
Secondary +	30.9	28.9	97	25.4	23.8	65
All	23.6	22.3	492	17.9	13.2	273

Table 4.5b: Use of contraception by sponsored vs non-sponsored areas

Percent distribution of currently married female adolescents by current reported use of any FP method according to sponsored & Non-sponsored unions.

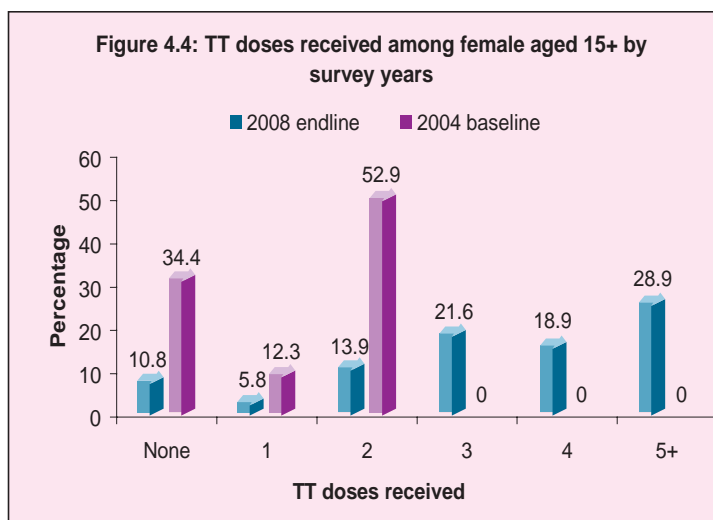
Background characteristics	Sponsored unions			Non-sponsored unions		
	Using any method	Using any modern method	N	Using any method	Using any modern method	N
Respondents' age:						
13-15	-	-	8	25.0	25.0	12
16-19	24.8	24.1	137	237	21.5	135
Highest education level:						
No Education	15.6	15.6	38	11.7	7.8	26
Primary	22.1	20.6	54	14.2	12.1	77
Secondary ⁺	30.9	28.9	53	22.9	21.7	44
All	24.7	22.3	145	14.4	11.7	147

4.10 Tetanus toxoid vaccination

Neonatal tetanus is a fatal disease caused by a pathogen transmitted under unhygienic condition at childbirth. For full protection, it is recommended that a pregnant women receive two doses of tetanus toxoid (TT). It is also recommended that a female adolescent age 15 or above should receive TT. Five doses of TT are considered to provide lifetime protection.

4.10.1 Awareness of TT vaccines

Adolescents, irrespective of sex and marital status, were asked whether they were aware of the need of for TT injections. Nearly 26 percent did not have any knowledge about TT injections. Awareness was much lower among males (40.6 percent have no knowledge) than females (12.9 percent have no knowledge). Among those who reported knowing the need for TT, the stated reasons were to protect women from five/six diseases (34.9 percent), TT is required to protect mother and child from tetanus (33.8 percent), TT is required during pregnancy (21.2 percent), and to protect mother/women from tetanus (10.3 percent).



Comparing the above findings with the baseline estimates of 2004, it can be said that awareness about the need of TT for women/girls has increased both amongst girls and boys (Table 4.6).

Table 4.6: Awareness of the need for TT vaccines				
Percent distribution of male and female adolescents by their awareness about the need for TT injection, according to survey years				
Awareness	2008 endline survey			2004 baseline survey
	Male	Female	All	
Awareness of the need of TT:				
To protect mother & child from tetanus	24.8	41.8	33.8	10.1
To protect mother/girl from tetanus	8.5	11.9	10.3	10.0
To protect child from tetanus	9.9	9.4	9.6	5.9
TT is required during pregnancy	18.2	23.9	21.2	25.5
To protect from five/six diseases	22.9	45.5	34.9	28.7
Others	-	-	-	0.2
Don't know	40.6	12.9	25.9	37.7
N	424	481	905	941

4.10.2 Receiving TT vaccines

All married and unmarried female adolescents of age 15 years or more were asked whether they had received any TT injection. Table 4.7 shows that 10.6 percent reported not receiving any TT, 29 percent received 5+ doses, 21.7 percent received 3 doses, 19 percent received 4 doses, and 14.0 percent received two doses. These results show that significant improvement occurred in receiving TT by 15+ adolescent girls over the last four years. In 2008, 89 percent reported receiving TT against 66 percent in 2004. In 2004, only 4 percent received 5+ doses; the corresponding figure is 29 percent in 2008.

Table 4.7: Tetanus toxoid (TT) vaccination				
Percent distribution of married and unmarried female adolescents age 15+ by number of TT doses received, according to survey years.				
TT doses received	2008 endline survey			2004 baseline survey
	Married female	Unmarried female	All	
None	9.6	12.8	10.8	34.4
1	5.0	7.2	5.8	12.3
2	12.3	16.7	13.9	52.9
3	21.6	21.7	21.6	-
4	18.9	18.9	18.9	-
5+	32.6	22.8	28.9	-
Don't know	-	-	-	0.4
N	301	180	481	454

Table 4.7a: Tetanus toxoid (TT) vaccination by sponsored and non-sponsored areas						
Percent distribution of married and unmarried female adolescents age 15+ by number of TT doses received, according to sponsored & non-sponsored unions						
TT doses	Sponsored unions			Non-sponsored unions		
	Married female	Unmarried female	All	Married female	Unmarried female	All
None	10.6	10.5	10.5	8.7	14.9	11.1
1	6.0	7.0	6.3	4.0	7.4	5.3
2	9.3	23.3	14.3	15.3	10.6	13.5
3	20.5	19.8	20.3	22.7	23.4	23.0
4	18.5	17.4	18.1	19.3	20.2	19.7
5+	35.1	22.1	30.4	30.0	23.4	27.5
N	151	86	237	150	94	244

Table 4.7a shows that prevalence of TT vaccines is higher among 15+ adolescent girls in sponsored areas than among those of non-sponsored areas.

4.11 Attitude of parents towards ARSH

Parent's attitude towards ARSH is a very important consideration in any adolescent-focused health program. To assess this, the survey asked parents whether adolescent boys and girls should have access to RH information/services and whether they would permit their adolescent boys/girls to participate in RH related programs.

About 99 percent reported that adolescent boys and girls should have access to RH information and services and that they would allow their adolescent boys/girls to participate in ARSH programs.

In response to a question on whether parents discuss RH issues with their adolescent son/daughter, about 30 percent replied in the affirmative. This was only 11 percent in 2004 at baseline survey time (Table 4.8).

Table 4.8: Attitude of parents towards ARSH		
Percent distribution of parents by attitude towards ARSH, according to survey years.		
Question	Survey years	
	2008 endline survey	2004 baseline survey
Whether think that adolescent boys and girls should have access to RH information and services?		
Yes	98.9	97.1
No	1.1	2.9
Whether permit to participate in a RH program:		
Yes	98.8	97.7
No	1.2	2.3
Whether discuss RH issues with adolescents son/daughter:		
Yes	29.8	11.3
No	70.2	88.7
N	890	310
Reasons for discussing RH matters:		
They will be aware/ benefited	74.0	
They will be able take care/ will not be worried	5.3	
Children of this age should know about RH	3.0	
If are do not educates them on RH, who will do this	1.5	
To protect them from risks/danger	3.4	
To remove misconception/worries	2.3	
To seek health care for them if needed	12.1	
N	265	
Reasons for not discussing RH matters:		
Feel shy/do not like	67.0	
Discussing RH issues will make them bad	12.8	
They may not respect us	1.8	
Will know everything when they will be adult	6.4	
Parents should not discuss RH issues with children	10.2	
Children feel shy if parents discuss RH issues	0.5	
Not aware/don t know anything about RH for discussion	6.7	
Other	0.8	
N	625	

Among those who said that they discuss RH issues with their son/daughters, the stated main reasons for discussion were: they will be aware/benefited and adolescents will be able to seek care if needed.

As reasons for not discussing RH issues with adolescent sons/daughters, feel shy/do not like, it will make them bad, and parents should not discuss RH issues with children were the main reasons for lack of discussion.

The prevalence of parent's discussion on RH issues with their children was not significantly different between sponsored and non-sponsored unions (Table 4.8a).

Table 4.8a: Discussion by sponsored and non-sponsored unions			
Percent distribution of parents by discussion with adolescent boys/girls about ARSH issues, according to sponsored & non-sponsored unions.			
	Percentage		
	Sponsored unions	Non-sponsored unions	All
Whether think that adolescent boys and girls should have access to RH information and services?			
Yes	100.0	97.5	98.9
No	-	2.5	1.1
Whether permit to participate in a RH program:			
Yes	99.8	97.5	98.8
No	0.2	2.5	1.2
Whether discuss RH issues with adolescents son/daughter:			
Yes	22.3	38.7	29.8
No	77.7	61.3	70.2
N	484	406	490
Reasons for discussing RH matters:			
They will be aware/ benefited	74.1	73.9	74.0
They will be able take care/ will not be worried	5.6	5.1	5.3
Children of this age should know about RH	2.8	3.2	3.0
If are do not educates them on RH, who will do this	-	2.5	1.5
To protect them from risks/danger	1.9	4.5	3.4
To remove misconception/worries	3.7	1.3	2.3
To seek health care for them if needed	15.7	9.6	12.1
N	108	157	265
Reasons for not discussing RH matters:			
Feel shy/do not like	71.0	61.0	67.0
Discussing RH issues will make them bad	11.2	15.3	12.8
They may not respect us	1.1	2.8	1.8
Will know everything when they will be adult	6.1	6.8	6.4
Parents should not discuss RH issues with children	7.2	14.9	10.2
Children feel shy if parents discuss RH issues	0.8	-	0.5
Not aware/don t know anything about RH for discussion	9.8	2.0	6.7
Other	0.8	0.8	0.8
N	376	249	625

5

KNOWLEDGE AND PERCEPTION ABOUT AIDS AND OTHER STIs

This section presents findings on adolescent's knowledge and perception about HIV/AIDS and other sexually transmitted infections (STIs). Knowledge about mode of transmission and ways to avoid HIV/AIDS and other STIs by male-female and marital status are presented. Comparisons are made between endline and baseline knowledge and also between sponsored and non-sponsored unions.

5.1 Knowledge and perception about HIV/AIDS

Physical and psychological push factors such as the inability to tackle emotional pain, conflicts, anxieties about the future, peer pressure and sexual curiosity are often the driving force for high risk behaviour among adolescents. Adolescents are often unable to comprehend fully the extent of their exposure to risk, which makes them particularly vulnerable to HIV and other sexually transmitted infections (STIs). Questions were asked to assess adolescents' knowledge and perceptions relating to HIV/AIDS and other STIs.

Table 5.1a shows that 71.5 percent of adolescents have heard of HIV/AIDS. This figure is 5.5 percentage points higher than the baseline (2004) figure, which was 66 percent. Awareness of HIV/AIDS is higher among male respondents than among female respondents.

When asked about the mode of transmission of HIV/AIDS, a majority of adolescents could mention one or more modes of transmission (Table 5.1a and Figure 5.1).

Of the adolescents who could mention the modes of transmission of HIV/AIDS, most mentioned use of non-sterile needles/syringes, sex with HIV/AIDS infected person, sexual contact with others except spouse, receiving unscreened blood and not using a condom during sex.

Knowledge about modes of HIV/AIDS transmission appear to be approximately the same as recorded in the baseline survey report of 2004. Knowledge of at least two (or at least three) modes of HIV/AIDS transmission by survey years (2004 & 2008) are almost identical.

A similar pattern was also observed in knowledge about ways to prevent HIV/AIDS. Use of condom, avoiding unscreened blood transfusion limiting sex within marriage and abstinence from sex and were the most cited ways of preventing HIV/AIDS (Table 5.1a, 5.1b). Knowledge of at least two and at least three ways of avoiding HIV/AIDS are also estimated and presented in Table 5.1b. No significant difference in knowledge was found between the endline and baseline surveys.

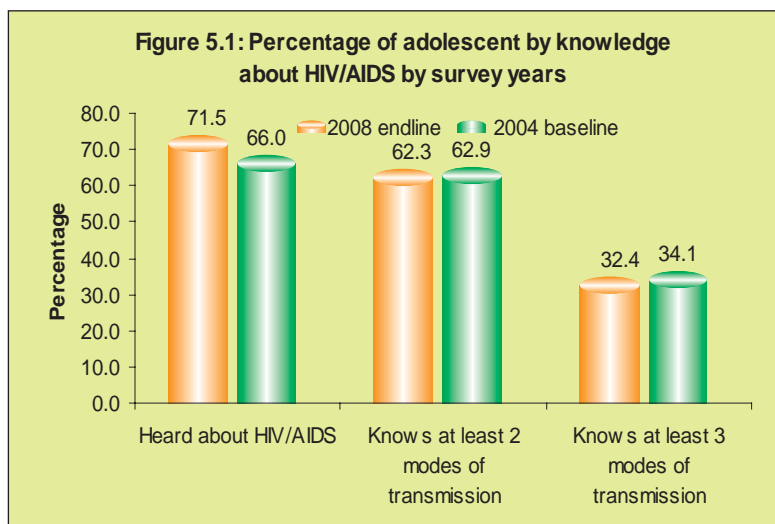


Table 5.1a: Knowledge of HIV/AIDS and mode of transmission						
Percentage of adolescents by knowledge of HIV/AIDS and mode of transmission, according to survey years.						
Knowledge	2008 endline survey					2004 baseline survey
	Married Male	Unmarried Male	Married Female	Unmarried Female	All	
Heard about HIV/AIDS:						
Yes	75.4	84.1	65.8	62.2	71.5	66.0
No	24.6	15.9	34.2	37.8	28.5	34.0
N	199	301	301	299	1100	1512
Knows mode of transmission:						
Sex with AIDS infected person	36.0	54.9	32.8	33.9	40.8	26.
Receiving untested blood	18.0	38.3	19.7	32.8	28.5	22.5
Use non-sterile needles/ syringes	34.0	58.5	32.8	43.0	42.7	36.4
Through pregnancy by a HIV positive mother	1.3	9.9	2.0	3.8	4.8	8.4
Through breast feeding by a HIV Positive mother	1.3	8.7	1.5	5.9	4.8	6.3
For not using a condom	31.3	25.3	5.1	2.2	15.9	15.6
By having sex with sex workers	43.3	37.5	8.6	7.0	24.1	25.5
Sexual contact with someone except spouse	41.3	29.2	29.8	24.7	30.6	57.9
Others						0.2
Don't Know	11.3	7.9	30.8	28.5	19.2	21.4
Knows at least two modes of transmission	71.3	77.9	44.9	52.2	62.3	62.9
Knows at least three modes of transmission	36.7	51.4	15.2	21.5	32.4	34.1
N	150	253	198	186	787	998

Table 5.1b: Knowledge of HIV/AIDS						
Percentage of adolescents by knowledge of not spreading, ways to avoid and possible actions for addressing HIV/AIDS, according to survey years.						
Knowledge	2008 endline survey					2004 baseline survey
	Married Male	Unmarried Male	Married Female	Unmarried Female	All	
Knows measures for not spreading HIV/AIDS:						
Avoid sex with infected partner	39.3	53.0	30.3	34.4	40.3	29.2
Use condom	44.0	46.6	14.1	13.4	30.1	31.0
Limit sex within marriage	19.3	7.9	22.2	14.0	15.1	32.9
Avoid sex with sex workers	40.7	32.8	9.6	6.5	22.2	27.7
Avoid sex with persons who have many partners	1.3	0.4	0.5	2.2	1.0	2.8
Avoid sex with homosexuals	4.0	0.8	-	-	1.0	0.5
Avoid untested blood transfusion	14.0	33.6	18.2	26.3	24.3	20.7
Avoid using non-sterile needles/ syringes	29.3	56.5	29.8	38.2	40.3	32.9
Avoid pregnancy HIV positive mother	1.3	5.5	1.0	2.2	2.8	4.2
Avoid breast feeding HIV positive mother	-	4.3	2.0	4.3	2.9	5.8
Don't know	12.7	8.7	31.8	30.1	20.3	18.4
Knows at least two measures	69.3	77.1	43.9	46.8	60.1	58.9
Knows at least three measures	30.0	43.1	13.6	19.4	27.6	31.5
Knows ways to avoid HIV/AIDS:						
Use condom	58.7	63.2	15.2	16.7	39.3	38.1
Limit sex within marriage	28.7	10.3	29.3	19.9	20.8	29.9
Abstinence	36.0	34.8	21.2	23.1	28.8	36.7
Avoid untested blood transfusion	14.7	40.7	19.2	29.6	27.7	17.6
Avoid using non-sterile needles/ syringes	22.0	51.4	28.3	33.3	35.7	36.8
Follow religious law	8.0	11.9	1.5	4.8	6.9	3.2
Avoid sharing razors/blades	6.7	5.9	2.5	2.7	4.4	6.5
Others	-	-	0.5	0.5	0.3	0.1
Don't know	12.0	9.1	33.8	33.9	21.7	19.9
Know at least two ways	63.3	72.7	38.4	43.5	55.4	50.9
Know at least three ways	20.7	39.9	11.6	15.6	23.4	18.7
N	150	253	198	186	787	998

5.2 Knowledge and perception about other STIs

Adolescents age 15 years or more were asked questions related to STIs other than HIV/AIDS. About 25 percent of adolescents had heard of other STIs. The percentage of adolescents who have heard about STIs appears to be slightly lower now than at the baseline time in 2004, while the percentage of adolescents who are able to cite reasons for transmission has increased. The most cited modes of STI transmission are similar to those as recorded in the baseline report. These include unhygienic practices, extramarital sex and sex with infected partner. About 55 percent of adolescents could mention at least two modes of STI transmission. The corresponding figure was 46.7 percent at the baseline time.

As reported in the baseline report, hygienic practice, limiting sex within marriage and use of condom were the most cited ways to avoid getting STIs.

Among those adolescents who were aware of STIs, 56.5 percent in 2008 against 37.4 percent in 2004 could mention at least two ways of protection from STIs.

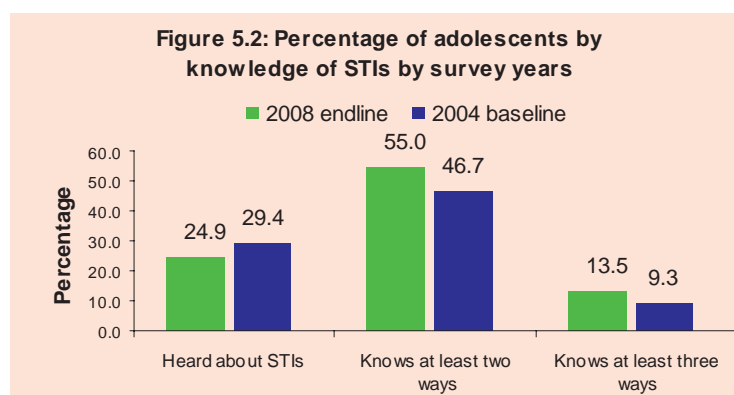


Table 5.2: Knowledge of other STIs

Percentage of adolescents aged 15-19 by knowledge of STIs other than HIV/AIDS, according to survey years.

Knowledge	2008 endline survey					2004 baseline survey
	Married Male	Unmarried Male	Married Female	Unmarried Female	All	
Heard about other STIs:						
Yes	16.1	47.4	18.6	18.5	24.9	29.4
No	83.9	52.6	81.4	81.5	75.1	70.6
N	199	194	279	130	802	773
Knows ways how STI spreads:						
Sexual contact with infected partner	34.4	40.2	13.5	8.3	28.5	25.6
Sexual contact except spouse	50.0	56.5	30.8	37.5	46.5	44.5
Unprotected sex	3.1	15.2	11.5	8.3	11.5	14.1
Sharing other's undergarments/towels	18.8	19.6	-	4.2	12.5	18.1
Sharing soap/ dirty toilets	-	7.6	11.5	20.8	9.0	3.5
Unhygienic practice	56.3	45.7	67.3	70.8	56.0	34.8
Don't know	9.4	2.2	7.7	12.5	6.0	16.1
Knows at least two ways	65.6	62.0	38.5	50.0	55.0	46.7
Knows at least three ways	6.3	21.7	3.8	12.5	13.5	9.3
Knows ways to avoid getting STI:						
Use condom	50.0	57.6	15.4	33.3	42.5	34.4
Limit sex within marriage	15.6	17.4	25.0	25.0	20.0	23.3
Abstinence	18.8	27.2	11.5	8.3	19.5	21.6
Avoid unscreened blood transfusion	3.1	18.5	7.7	12.5	12.5	5.3
Avoid using non-sterile needles/ syringes	-	20.7	7.7	12.5	13.0	6.6
Follow religious law	12.5	14.1	1.8	-	9.5	2.6
Hygienic practice	59.4	46.7	69.2	54.2	55.5	43.6
Others	-	1.1	-	-	0.5	-
Don't know	9.4	3.3	9.6	12.5	7.0	16.7
Knows at least two ways	56.3	64.1	48.1	45.8	56.5	37.4
Knows at least three ways	12.5	28.3	1.9	8.3	16.5	12.8
N	32	92	52	24	200	227

6

UTILIZATION OF HEALTH SERVICES

Issues related to utilization of health care facilities by adolescents for reproductive health problems are presented in this section. Utilization of health care facilities by adolescents for reproductive health problems depends on many factors. Bangladesh's society is conservative and various gender inequalities exist within it. For most adolescents, talking about reproductive health or sexuality is embarrassing. In such an environment, it is difficult for adolescents to obtain reproductive and sexual health related information or services. Unless adolescents are aware of health facilities in their community as well as the types of services that are available in those facilities, utilization will be low. These facts should be kept in mind while interpreting findings on utilization of health services.

6.1 Utilization of reproductive health services

Adolescents were asked whether they had visited any hospital/provider for reproductive health care and/or information in the year preceding the survey and, if they did then for what type of problems/information and where did they go for care. Table 6.1 gives percent distribution of adolescents who did or did not seek care, the type of problems for which care was sought and the sources of care, according to survey years.

Table 6.1 shows that utilization of health facilities for reproductive health services and/or information by adolescents seems to be low. Only 19.5 percent of adolescents visited a health facility to receive some kind of service and/or information in the year preceding the survey. Among those who reported of seeking care from a facility, the major problems for which treatment was sought were lower abdominal pain, antenatal care or irregular/painful menstruation for girls and wet dreams for boys. The facilities they used for their last visit were traditional/ village doctors, private doctor/clinic and upazila health complexes (Table 6.1). Utilization of RH services appears to higher now (19.5 percent) than at baseline time in 2004 (13.6 percent).

Table 6.1 Utilization of RH services

Percent distribution of adolescents who sought RH care/information from a source in the one year preceding the survey, by type of problems and sources of care, according to survey years.

	2008 endline survey			2004 baseline survey
	Male	Female	All	
Sought RH care/information in last one year:				
Yes	16.2	22.2	19.5	13.6
No	83.8	77.8	80.5	86.4
N	500	600	1100	1512
Problems for which treatment sought:				
Irregular/painful menstruation	-	16.5	10.3	9.3
Abnormal vaginal discharge	-	12.0	7.5	3.4
Lower abdominal pain	1.2	34.6	22.0	13.2
Excessive bleeding	-	4.5	2.8	1.5
Foul smell of the menstrual blood	-	0.8	0.5	-
Itching in genital area	19.8	3.8	9.8	5.9
ANC	2.5	30.1	19.6	19.5
Delivery	1.2	5.3	3.7	2.0
PNC	-	2.1	1.4	3.9
TT for unmarried girls	-	13.5	8.4	29.3
Wet dream	56.8	-	21.5	9.3
Contraceptive/Family Planning	-	2.3	1.4	2.4
Pain /burning sensation passing urine	12.3	3.0	6.5	2.0
Syphilis	2.5	-	0.9	0.5
Pus from penis	19.8	3.0	9.3	4.4
Infertility	1.2	4.5	3.3	5.4
Penile discharge	1.2	-	0.5	1.0
N	81	133	214	205
Sources of care for last service received:				
District hospital	6.2	11.3	9.3	3.9
Family Welfare Centre	1.2	6.0	4.2	7.8
Upazila Health Complex	13.6	21.1	18.2	10.7
MCWC	-	-	-	0.5
Rural dispensary/Community clinic	-	-	-	1.0
Govt satellite clinic/EPI center	-	8.3	5.1	30.7
NGO static clinic	1.2	2.3	1.9	2.4
NGO satellite clinic	1.2	0.8	0.9	2.9
NGO fieldworker	1.2	5.3	3.7	1.0
NGO depholder	1.2	0.8	0.9	0.5
Private clinic/doctor	17.3	16.5	16.8	11.2
Traditional doctor	34.6	15.0	22.4	19.0
Pharmacy	22.2	12.8	16.4	5.4
KAISHAR program	-	-	-	1.0
Others	-	-	-	5.0
N	81	133	214	205

6.2 Utilization of Reproductive Health services by sponsored and non-sponsored unions

Table 6.2 gives utilization of RH care services by adolescents in sponsored and non-sponsored unions. Care seeking behaviour appears to be higher among adolescents in sponsored unions.

Table 6.2 Utilization of RH services						
Percent distribution of adolescents who sought RH care/information from a source in the last one year preceding the survey and sources of care, according to sponsored & non-sponsored area.						
	Sponsored area			Non-sponsored area		
	Male	Female	All	Male	Female	All
Sought RH care/information in last one year:						
Yes	15.4	23.7	19.9	17.0	20.7	19.0
No	84.6	76.3	80.1	83.0	79.3	81.0
N	259	300	559	241	300	541
Problems for which treatment received:						
Irregular/painful menstruation	-	12.7	8.1	-	21.0	12.6
Abnormal vaginal discharge	-	5.6	3.6	-	19.4	11.7
Lower abdominal pain	2.5	21.1	14.4	-	50.0	30.1
Excessive bleeding	-	4.2	2.7	-	4.8	2.9
Foul smell of the menstrual blood	-	1.4	0.9	-	-	-
Itching in genital area	17.5	1.4	7.2	22.0	6.5	12.6
ANC	5.0	32.4	22.5	-	27.4	16.5
Delivery	-	5.6	3.6	2.4	4.8	3.9
PNC	-	-	-	-	4.8	2.9
TT for unmarried girls	-	21.1	13.5	-	4.8	2.9
Wet dream	72.5	-	26.1	41.5	-	16.5
Contraceptive/Family Planning	-	4.2	2.7	-	-	-
Pain /burning sensation passing urine	10.0	4.2	6.3	14.6	1.6	6.8
Syphilis	5.0	-	1.8	-	-	-
Pus from penis	12.5	2.8	6.3	26.8	3.2	12.6
Infertility	2.5	5.6	4.5	-	3.2	1.9
Penile discharge	2.5	-	0.9	-	-	-
N	40	71	111	41	62	103
Sources of care for last service received:						
District hospital	12.5	11.3	11.7	-	11.3	6.8
Family Welfare Centre	2.5	1.4	1.8	-	11.3	6.8
Upazila Health Complex	20.0	18.3	18.9	7.3	24.2	17.5
Rural dispensary/Community clinic	-	-	-	-	-	-
Govt satellite clinic/EPI center	-	15.5	9.9	-	-	-
NGO static clinic	2.5	4.2	3.6	--	-	-
NGO satellite clinic	-	1.4	0.9	2.4	-	1.0
NGO fieldworker	2.5	5.6	4.0	-	4.8	2.9
NGO depholder	2.5	1.4	1.8	-	-	-
Private clinic/doctor	17.5	16.3	18.0	36.6	14.5	15.5
Traditional doctor	32.5	16.9	22.5	36.6	12.9	22.3
Pharmacy	7.5	5.6	6.3	36.6	21.0	27.2
N	40	71	111	41	62	103

7

AWARENESS AND INVOLVEMENT IN KAISHAR PROGRAM

Save the Children's *KAISHAR* program in Nasirnagar was an adolescent-focused program aimed at developing awareness and life skill related to reproductive and sexual health. The endline survey attempted to assess adolescents' awareness about the *KAISHAR* program and their involvement in its activities.

7.1 Awareness about *KAISHAR* program

Survey results (Table 7.1) show that adolescents' awareness about the *KAISHAR* program and its activities and their participation in the program is significantly higher in 2008 as compared to 2004. About 52 percent of adolescents (57 percent of male and 47.5 percent of female) in 2008 against 37.6 percent in 2004 were aware of the *KAISHAR* program. About 35.4 percent perceive that ARSH-related activities of *KAISHAR* program brought changes among adolescents (the corresponding figure was 18.8 percent in 2004).

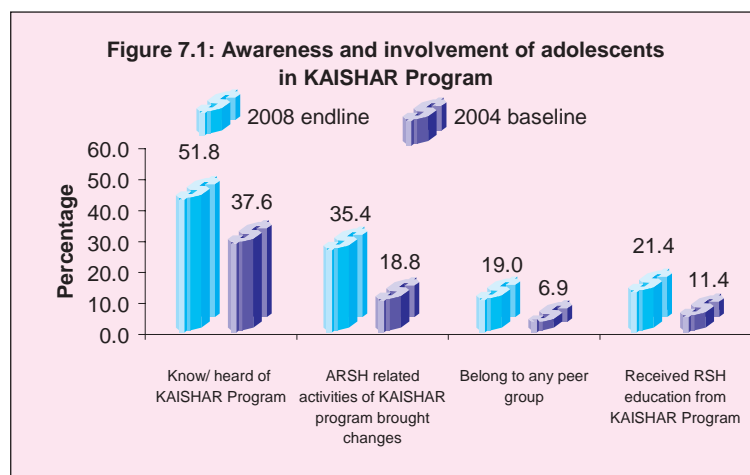


Table-7.1: Awareness and involvement of adolescents in *KAISHAR* Program
Percent distribution of adolescent by awareness and involvement in *KAISHAR* Program, according to survey years.

Awareness and involvement	2008 endline survey			2004 baseline survey
	Male	Female	All	
Awareness:				
Know/ heard of <i>KAISHAR</i> Program	57.0	47.5	51.8	37.6
ARSH related activities of <i>KAISHAR</i> program brought changes	36.6	34.3	35.4	18.8
Involvement:				
Belong to any peer group	17.0	20.7	19.0	6.9
Received RSH education from <i>KAISHAR</i> Program	19.8	22.7	21.4	11.4
N	500	600	1100	1512

Table-7.1a: Awareness and involvement of adolescents in *KAISHAR* Program by residence
Percent distribution of adolescent by awareness and involvement in *KAISHAR* Program, according to sponsored & non-sponsored area.

Awareness and involvement	Sponsored area			Non-sponsored area		
	Male	Female	All	Male	Female	All
Awareness:						
Know/ heard of <i>KAISHAR</i> Program	59.1	58.0	58.5	54.8	37.0	44.9
ARSH related activities of <i>KAISHAR</i> program brought changes	34.0	38.0	36.1	39.4	30.7	34.6
Involvement:						
Belong to any peer group	19.7	25.7	22.9	14.1	15.7	15.0
Received RSH education from <i>KAISHAR</i> Program	20.1	27.0	23.8	19.5	18.3	18.9
N	259	300	559	241	300	541

7.2 Involvement in KAISHAR program

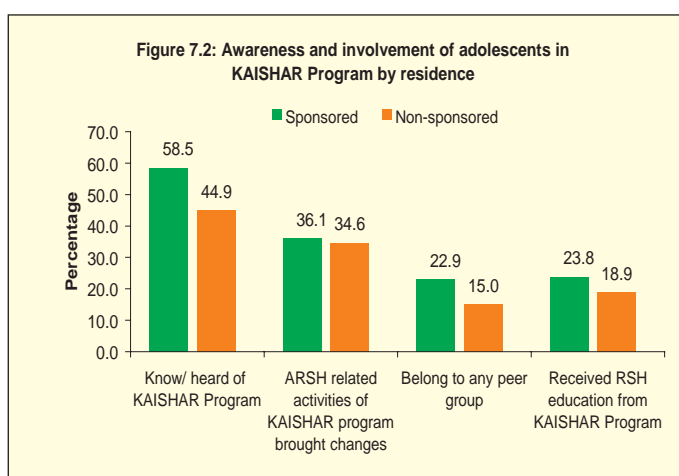
Involvement of adolescents in KAISHAR program was found to be 47.6 percent, which is 9.2 percentage points higher than baseline figure (38.4 percent). The main KAISHAR activities in which they participated were: KAISHAR meetings, discussion meetings, KAISHAR fairs, and youth-friendly education sessions.

All the adolescents (100 percent) opined that the KAISHAR program is an essential program for the adolescents of their area. Almost all of them were in favour of its continuation (Table 7.2).

7.2 Involvement in KAISHAR program

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7.3 Awareness and involvement by sponsored and non-sponsored areas

Table 7.3 shows adolescent's awareness about the KAISHAR program and their involvement in KAISHAR activities. Obviously, awareness and involvements were higher among adolescents of sponsored unions than among those of non-sponsored unions.

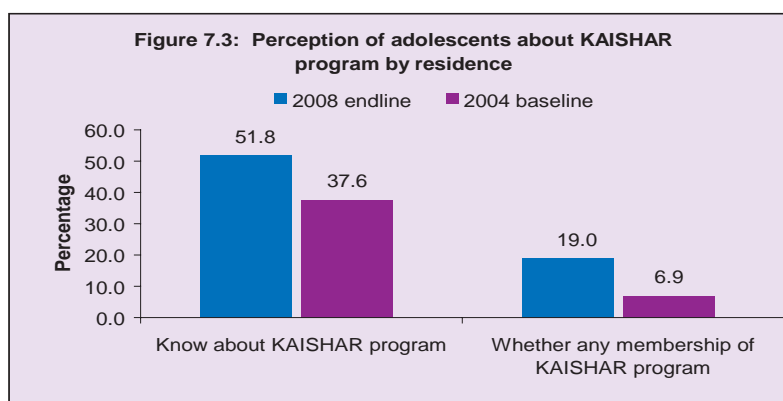


Table 7.2: Perception of adolescents about KAISHAR program				
Percent distribution of adolescents by perception of KAISHAR program and activities.				
	2008 endline survey			2004 baseline survey
	Male	Female	All	
Know about KAISHAR program:				
Yes	57.0	47.5	51.8	37.6
No	43.0	52.5	48.2	62.4
N	500	600	1100	1512
Whether any membership of KAISHAR program:				
Yes	17.0	20.7	19.0	6.9
No	83.0	79.3	81.0	93.1
N	500	600	1100	1512
Reasons for not involved/membership of KAISHAR program:				
We don't like	13.0	5.0	8.8	7.1
Child don't like	3.4	6.7	5.2	6.3
Child feel shy	5.8	4.2	4.9	1.6
Session ended / there is no activities in this area	16.9	21.6	19.4	21.2
Don't know about KAISHAR program	57.8	64.3	61.3	63.4
Others	4.6	0.2	2.2	0.7
N	415	476	891	1336
Participated in any activities of KAISHAR program				
Yes	46.8	48.3	47.6	38.4
No	53.2	51.7	52.4	61.6
N	233	240	473	451
Type of activities in the KAISHAR program:				
Youth-friendly education session	16.5	37.9	27.6	
Information center/corner for adolescents	11.0	1.7	6.2	
KAISHAR meetings	60.6	19.0	39.1	
Dialogue between adults & youths	13.8	11.2	12.4	
Rally	34.9	20.7	27.6	
Discussion meeting	32.1	41.4	36.9	
KAISHAR counseling	1.8	0.9	1.3	
Health center visits	2.8	7.8	5.3	
Workshop for unreached adolescent	-	5.2	2.7	
KAISHAR fair	34.9	37.9	36.4	
ARH educator at SC	2.8	18.1	10.7	
Opinion about KAISHAR				
Necessary	100.0	100.0	100.0	
Not necessary	-	-	-	
Opinion about the running of KAISHAR program:				
Yes	100.0	97.4	98.7	
No	-	2.6	1.3	
N	109	116	225	

8

DISCUSSION AND CONCLUSION

KAISHAR is an adolescent development program implemented by Save the Children in Nasirnagar.. The program aims to improve ARSH and adolescents' health seeking behaviour through a range of innovative measures such as creation of adolescent-friendly environments for essential services, expansion of access to sources of reproductive and sexual health information and fostering of support networks by linking adolescents with existing facilities as well as with informal sources of support such as peers, parents and other key adults.

Adolescents' awareness about reproductive health and reproductive health problems is generally low in Bangladesh, evidenced in both the 2004 baseline and 2008 endline surveys. However, within the KAISHAR program areas adolescents' knowledge and information was higher in 2008 than in 2004. Adolescent boys' knowledge of at least two pubertal changes increased by 22 percentage points (from 64 percent in 2004 to 88 percent in 2008). The percentage of females with no knowledge reduced from 9 percent in 2004 to 1 percent in 2008. Awareness about menstruation has increased by 17 percentage points among females aged 10-12 (from 42 percent in 2004 to 59 percent in 2008).

There was little difference in the level of awareness about RH problems among male and female adolescents, although each group was more aware of problems affecting their own gender. As perceived by male adolescents, wet dreams, itching in the genital area of men, pus from penis and pain or burning sensation while passing urine were the main reproductive health problems. According to female adolescents, lower abdominal pain, irregular or painful menstruation, abnormal vaginal discharge, and excessive bleeding were the common RH problems.

Past research has indicated that a gap usually exists between perception and actual practice related to age at marriage and age at first childbirth.¹ Although the endline survey did not collect information on ideal age at marriage and age at first childbirth, the actual age at marriage and actual age at first pregnancy and childbirth were found to be low at 15.4 years, 15.7 years and 15.9 years respectively. These estimates are slightly higher than baseline estimates. Age at marriage and age at first childbirth were approximately the same in sponsorship and non-sponsorship unions.

Interpersonal communication such as discussion with peers, parents, and others is an effective way to provide reproductive health information and support. Health providers/facilities and schools can also serve as effective sources of RH information. In Bangladesh, adolescents have very limited access to reproductive health information and services; schools rarely provide RH information to youth and many adolescents do not discuss reproductive health issues with parents. Nationally, it is reported that only 37.6 percent of girls and 19.9 percent of adolescent boys discuss pubertal changes with parents, and 37 percent of girls and 61.0 percent of boys discuss the issue with friends and peers.² Discussion about their marriage and marriage partners with parents is even lower. It was reported that most adolescent discussions about RH and marriage issues take place among friends and peers.³

¹ Khan, et al (2003, 2004)

² Ibid

³ Ibid

The endline survey 2008 found adolescent girls more likely to discuss reproductive health issues with others than boys. However, girls were less likely to have discussions regarding their marital partners than are boys. Among both genders, in-laws and friends were the main discussion partners. These findings are similar to those as recorded in the baseline.

The prevalence of contraceptive use among married female adolescents in Nasirnagar increased by 5.7 percentage points (from 17.9 percent in 2004 to 23.6 percent in 2008). However, this is still substantially lower than the national rate of contraception use among adolescents. Use of any family planning method and use of modern methods are significantly higher in sponsored unions (25 percent) than non-sponsored unions (14 percent).

About 11 percent of married and unmarried females aged 15 or older did not receive any tetanus toxoid injection. About 29 percent received 5 or more doses of TT, 22 received 3 doses, and 19 percent received 4 doses. These results show significant improvement in receipt of TT by 15 years or older adolescent girls over the last four years (against 66 percent in 2004, 89 percent in 2008 reported receiving any vaccine).

Awareness about HIV/AIDS among adolescents and parents is high, but still lower than the national estimate. About 72 percent of adolescents in the program area had heard about HIV/AIDS. The majority of these could mention at least two modes of transmission and two ways of preventing HIV/AIDS. It may be noted that the number of adolescents who had heard about other STIs stands approximately at slightly less than was recorded in 2004 baseline report, though the number who could identify modes of transmission increased. Nationally, it is reported that less than 5 percent adolescents are aware of STIs,⁴ whereas about 25 percent adolescents in the program area are aware. Among those who were aware of STIs, 55 percent could mention at least two modes of STI transmissions.

Utilization of health care facilities for RH services and/or information by adolescents was reported to be low. Only about one-fifth visited health facilities in the one year preceding the survey. However utilization is higher in 2008 (20%) than in 2004 (14%).

Adolescents' awareness about the *KAISHAR* program and its activities and their participation in it was found higher in 2008 than in 2004. About 52 percent of adolescents against 38 percent in the baseline were found aware of *KAISHAR* program. Nearly 48 percent were found to be involved in *KAISHAR* activities, which is 9 percentage points higher than baseline figure. Almost all the adolescents perceived that *KAISHAR* is an essential program for adolescents which should continue.

Conclusion and recommendation

It is not possible to measure impact of a program like *KAISHAR* after a short duration of time. It takes a longer time change behaviour. However, the survey results show that there has been a change/improvement in knowledge, attitudes and practices of adolescents regarding reproductive and sexual health. But overall it can be said that *KAISHAR* program is a potential exercise for the development of Adolescent Reproductive and Sexual Health.

⁴ Ibid



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21

QUESTIONNAIRE

Batch Number

Converted Number

**FOEMJOF!TVSWFZ!PG!BEPMFTDFOU!SFQSPEVDUJWF!IFBMUI!QSPHSBN!
#LBJTIBS#!JO!OBTJSOBHBS**

BEPMFTDFOU!RVFTUJPOOBJSF

WORK RECORD					
	INTERVIEWED BY	SUPERVISED AND FIELD EDITED BY	OFFICE EDITED BY	CODED BY	ENTERED BY
NAME					
DATE	<input type="text"/> DAY MONTH	<input type="text"/> DAY MONTH	<input type="text"/> DAY MONTH	<input type="text"/> DAY MONTH	<input type="text"/> DAY MONTH

EBUB!DPMMFDUFE!CZ

BTTPDJBUFT!GPS!DPNNVOJUZ!BOE!QPQVMBUJPO!SFTFBSDI!)BDQS*
3/10, Block A, Lalmatia, Dhaka-1207, Bangladesh

**JO!DPMMBCPSBUJPO!XJUI!
TBWF!UIF!DIJMESFO**

FACE SHEET FOR ADOLESCENT QUESTIONNAIRE

SAMPLE IDENTIFICATION

Union: _____ Village: _____

Address (Village, Para): _____

Adolescent line number

Household Number

Name of Adolescent: _____ Name of HH Head: _____

INTERVIEW INFORMATION

Interviewer visits	1	2	3	4
Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Day Month
Interviewer's code	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Result*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Result Code

- | | |
|--------------------------|----------------------------|
| 1 Completed | 3 Refused/Deferred |
| 2 Not available | 4 Respondent incapacitated |
| 5 Others (specify) _____ | |

TFDUJPO!J;!CBDLHSPVOE!DIBSBDUFSJTUJDT

	QUESTION	RESPONSE		SKIP
101.	How old were you at your last birthday?	Years old <input type="text"/> <input type="text"/>		
103.	What is your religion?	Islam Hinduism Christianity Buddhism Others (Specify)	1 2 3 4 6	
104.	Have you ever-attended school/college?	Yes No	1 2	→ 105
104	Are you currently attending school/ college?	Yes No	1 2	→ 104c
104	What is the highest class have you passed?	Class <input type="text"/> <input type="text"/>		→ 105b
104c	What class do you read in currently?	Class <input type="text"/> <input type="text"/>		
105.	Do you work for earning income?	Yes No	1 2	
105	What is your main occupation now?	Student Housewife Skilled worker Service Trading Shopkeeper Farming Boatman/tempo driver ... Ricksha puller Day laborer Poultry Cattle raising Kitchen gardening Fisher man Tutionee Nothing Other (Specify)	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 96	

TFDUJPO!JJ;!NBSSJBHF-!BOD-!QOD

	QUESTION	RESPONSE		SKIP
201.	Have you ever been married?	Yes No	1 2	→ 208a
201a.	How old were you when you got married?	Age <input type="text"/> <input type="text"/>		
210b.	Have you/your wife ever been got pregnant?	Yes No Currently pregnant	1 2 3	→ 201f
201c.	How old were you/your wife during 1 st pregnancy?	Age <input type="text"/> <input type="text"/>		
201d.	Do you have children?	Yes No	1 2	→ 201f
201e.	How old were you/your wife when the 1 st child was born?	Age <input type="text"/> <input type="text"/>		
201f.	What is your current marital status?	Currently married Widowed Divorced Separated	1 2 3 4	→ 204
202.	Are you or your spouse currently doing (or using) anything to avoid having children?	Yes No	1 2	→ 202b
202a.	What are you or your spouse currently doing (or using) to avoid having children?	Pill Condom Injection Norplant IUD Female sterilization Male sterilization Rhythm/Safe period Withdrawal Others(Specify) Don't know	01 02 03 04 05 06 07 08 09 10 96	
203.	Did you/your wife ever receive any TT Vaccine?	Yes No Don't know	1 2 7	→ 208e
20a.	How many TT vaccine did you/your wife receive?	Dose <input type="text"/> Don't know		7

	QUESTION	RESPONSE		SKIP
203b.	Do you know why TT Injection is required for a woman?	To protect mother & child from tetanus To protect mother/girl from tetanus To protect child from tetanus TT is required during pregnancy ... To protect from five/six diseases .. Other _____ (Specify) Don't know	A B C D E X Y	→ 208g
203c.	How many TT doses are required for the lifetime protection (15-49 years) for a women?	Doses <input type="text"/> Don't know		97

!

**TFDUJPO!JJJ;!QFSDFQUJPO!BOE!BUUJUVEF!UPXBSET!BEPMFTDFOU!
SFQSPEVDUJWF!BOE!TFYVBM!IFBMUI!JTTVFT**

	QUESTION	RESPONSE		SKIP
301.	What do you mean by reproductive health? PROBE	Physical changes of adolescent.... Mental changes of adolescent Reproductive organs of male..... Reproductive organs of female Function of reproductive organs .. Menstruation..... Wet dream Process of child birth..... Care of reproductive organs..... Care of physical changes of adolescent..... Care of mental changes of adolescent..... Marriage..... Pregnancy Family Planning..... To avoid different diseases of reproductive organs..... To create harassment free environment/protect from harassment About reproduction..... Other (Specify) Don't know	A B C D E F G H I J K L M N O P Q X Y	

	QUESTION	RESPONSE		SKIP
302.	With whom you feel free to talk about marriage time ?	Father..... Mother..... Grand mother Grand father Sister/brother Sister/brother in law Aunt Uncle Other _____ (Specify) Nobody	A B C D E F G X Y	
302a.	With whom you feel free to talk with about your marriage partner?	Father..... Mother..... Grand mother Grand father Sister/brother Sister/brother in law Aunt Uncle Other _____ (Specify) Nobody	A B C D E F G X Y	
303.	Have you ever heard about menstruation?	Yes..... No.....	1 2	→ 401
303a.	With whom you feel free to talk with about menstruation?	Father..... Mother..... Grand mother Sister..... Sister in law Aunt Husband..... Other _____ (Specify) Nobody.....	A B C D E F X	

	QUESTION	RESPONSE		SKIP
303b.	Do you think that any food restriction is required for menstruating girls?	Yes No Don't know	1 2 7	
303c.	Do you believe that menstruating girls could move freely anywhere such as schools, community etc.?	Yes No Don't know	1 2 7	→ 401
304.	What are the physical changes/problems that a boy experiences during adolescence?	Hair grows in different parts of body Chest and shoulder widen..... Ejaculation starts Voice changes..... External genitalia develops Acne appears Frequent wet dream Other (Specify) Don't know	1 2 3 4 5 6 7 8 9	
304a.	With whom you feel free to talk with about wetdream?	Father..... Mother..... Grand mother Grand father Brother Sister/brother in law..... Uncle Other _____ (Specify)	A B C D E F X	
305	Do you discuss other RSH issues (except Marriage, Menstruation, wetdream) with your parents If yes why ? If no why ?			

TFDUJPO!JW;!IJW0BJET!BOE!TFYVBMMZ!USBOTNJUFE!EJTFBTFT!

	QUESTION	RESPONSE	SKIP
401.	Have you ever heard about HIV or AIDS?	Yes..... No.....	1 2 → 402
401a.	How does a person become infected with AIDS (the virus that causes AIDS)?	Sex with AIDS infected person..... Receiving unscreened blood..... Use non-sterile needles/ syringes..... Through pregnancy by a HIV positive Mother..... Through breast feeding by a HIV Positive mother..... For not using a condom..... By having sex with sex workers..... Sexual contact except spouse..... Others_____..... (Specify) Don't Know.....	A B C D E F G H X Y
401b.	What are the reasons that the AIDS virus does not spread out?	Avoid sex with infected partner..... Use condom..... Limit sex within marriage..... Avoid sex with sex workers..... Avoid sex with persons who have many partners..... Avoid sex with homosexuals..... Avoid unscreened blood transfusion.... Avoid using non-sterile needles/ syringes..... Avoid pregnancy HIV positive mother . Avoid breast feeding HIV positive mother..... Others_____..... (Specify) Don't know.....	A B C D E F G H I J X Y
401c.	What are all the ways a person can do to avoid getting HIV/AIDS?	Use condom..... Limit sex within marriage..... Abstinence..... Avoid unscreened blood transfusion.... Avoid using non-sterile needles/ syringes..... Follow religious law..... Avoid sharing razors/blades..... Others_____..... (Specify) Don't know.....	A B C D E F G X Y
401 d.	What one should do if s/he suffers from AIDS?	Seek treatment from a qualified doctor..... Instructions of doctor should be strictly followed..... Give opportunity to live in family/society with respect..... Careful about physical and mental problems..... Help from AIDS infected person..... Both partners should receive the	A B C D E F

	QUESTION	RESPONSE	SKIP
		treatment	G
		Keep separate AIDS infected person.....	H
		Give nutritious food/take care	I
		Keep cheerful/tensionless	I
		
		Others_____	X
		(Specify)	
		Don't know	Y
402.	CHECK Q. 101 AND CIRCLE IN APPROPRIATE CODE	Age 15 years or less	→ 1
		Age 15 above.....	2
402a	Have you heard about other sexually transmitted infections?	Yes	1
		No	→ 2
402b.	How does a person get other sexually transmitted infections?	Sexual contact with infected partner	A
		Sexual contact except spouse	B
		Unprotected sex	B
		Sharing other's undergarments/towels...	C
		Sharing soap/ dirty toilets	D
		Unhygienic practice	E
		Others_____	F
		(Specify)	X
		Don't know	Y
402c.	What can a person do to avoid getting a sexually transmitted infection?	Use condom.....	A
		Limit sex within marriage	B
		Abstinence	C
		Avoid unscreened blood transfusion.....	D
		Avoid using non-sterile needles/ syringes	E
		F
		Follow religious law.....	G
		Hygienic practice	X
		Others_____	
		(Specify)	Y
		Don't know	

**TFDUJPO;!W!SFQSPVUDUJWF!IFBMUI!FEVDBUJPO!BOE!VUJMJ[BUJPO!PG!
IFBMUI!TFSWJDFT**

	QUESTION	RESPONSE	SKIP	
501.	In the past 1 ← year, have you visited a health facility of any kind to receive services and (or) information on reproductive health?	Yes No	1 → 507	
501a.	For what kind of reproductive health information or services?	Irregular/painful menstruation. Abnormal vaginal discharge..... Lower abdominal pain..... Excessive bleeding Foul smell of the menstrual blood..... Itching in genital area ANC visit..... Delivery PNC visit TT for unmarried girls..... Wet dream Contraceptive/Family Planning. Pain /burning sensation passing urine Syphilis Pus from penis..... Infertility Penile discharge..... Others..... (Specify)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	
501b.	Which health facility have you visited to receive reproductive health information or services for the last time?	PUBLIC SECTOR District hospital Family Welfare Centre Upazila Health Complex MCWC Rural dispensary/Community clinic Satellite clinic/EPI outreach site NGO SECTOR Static clinic Satellite clinic Fieldworker Depotholder PRIVATE SECTOR Private clinic/doctor..... Traditional doctor..... Pharmacy..... TD!LBJI BS !qsphsbn Other (Specify).....	01 02 03 04 05 06 07 08 09 10 11 12 13 14 96	
502.	I would request you to answer the following questions:			
	Was the clinic hours convenient to you?	Yes No	1 2	

QUESTION		RESPONSE		SKIP
	a. Was the clinic hours convenient to you?	Yes	1	
		No	2	
	b. Which time is convenient for you?			
	c. Did you wait long before getting any service?	Yes	1	
		No	2	
	d. Was the sitting arrangement sufficient?	Yes	1	
		No	2	
	e. Did the service provider greeted you in a friendly manner?	Yes	1	
		No	2	
	f. Did you feel comfortable enough with the provider to clarify all of your questions?	Yes	1	
		No	2	
	g. During consultation was there enough privacy so that others could not hear you except for the service provider?	Yes	1	
		No	2	
	h. Was there enough privacy so that others could not see you except the service provider?	Yes	1	
		No	2	
	i. Did you feel confident that the information provided by you to the service provider would not be disclosed to others?	Yes	1	
		No	2	
	j. Did the service provider give enough explanations for your problems?	Yes	1	
		No	2	
	k. Did the service provider explain to you about the doses and timing of the prescribed medicine?	Yes	1	
		No	2	
	l. During the consultation, did you feel that the provider was easy to understand when explaining things to you or difficult to understand?	Yes, easy	1	
		No, difficult	2	
	m. Did the service provider counsel you on taking preventive measures for your problems?	Yes	1	
		No	2	
503.	Did the service provider examine you?	Yes	1	
		No	2	→ 504
503a.	Were the following conditions/environment present in the examination area?	Yes	1	
		No	2	
		i. Auditory privacy	1	2
		ii. Visual privacy	1	2
	(READ OUT ALL THE OPTIONS)	iii. Cleanliness (Swept floor with clean chair, tables and equipment)	1	2
		iv. Adequate light (Enough natural or electric light)	1	2
		v. Adequate water (Sufficient water for washing hands and equipment)	1	2

SECTION:VI PROGRAM ASSESSMENT

	QUESTION	RESPONSE	SKIP
601.	Are you aware of KAISHAR program?	Yes No	1 2 → 602
602.	Do you belong to any peer group?	Yes No	1 → 2 602c
602a.	Why you do not belong to any peer group?	Don't like Parent does not like Feel shy Session ended There is no activities in this area Don't know about KAISHAR program Other (Specify)	1 2 → 603 3 4 5 → 606 6 7 → 603 8
603.	Have you received any reproductive and sexual health education from KAISHAR program or peer educator?	Yes No	1 2
604.	Do you think that reproductive and sexual health related activities of KAISHAR program brought changes for adolescent of this area?	Yes No Not aware about ARSH program	1 2 3

Interviewer: Before leaving (the respondent) check the questionnaire carefully; After thorough checking, stop interviewing and then thank him/her sincerely for sparing her/his valuable time with you.



Save the Children

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