Baseline Survey of Adolescent Reproductive Health Interventions in Bangladesh

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PREFACE

Adolescents constitute an important socio-demographic group of Bangladesh both because of their sheer numbers of Bangladesh's population, and their significance for the present and the future of the country. The adolescents are by nature inquisitive, emotional and quite apt to get attracted in new things and venture. This is the age when boys and girls start having changes in their body associated with puberty, menstruation and other reproductive health issues. These changes in body make them curious, raise so many questions in their mind and sometime make them worried about unknown things, which in the long run affect their physical and mental health. It was revealed in the research studies that boys and girls are found to get it difficult to cope with the accompanying stress, get shy or do not find anyone reliable to discuss with and, considering those issues as 'taboo' subjects, parents, grandparents and other elder family members do not discuss those things with the adolescents. As a result the adolescents become vulnerable to harmful influences on reproductive and sexual health.

BCCP is in the process of launching a number of BCC interventions for the adolescents of the country in an effort to help them learn and look after their physical health as well as to help them develop morally and acquire a positive outlook on life. At the initiation of the program this baseline survey has been conducted. Objectives of the Baseline Survey are to obtain attitudinal and knowledge level of the adolescents which will also be relevant for evaluating the impact of the media interventions in Bangladesh. This baseline survey provides valuable baseline information on adolescent reproductive and sexual health, health needs and health care seeking behavior as well as background information. I believe the findings of the survey will greatly serve to plan any programs for adolescents.

It is gratifying to note that this important survey was successfully possible due to the relentless effort of the concerned staff of BCCP and Associates for Community and Population Research (ACPR). I am grateful to USAID for providing the financial assistance necessary for the study. We appreciate the inputs made by Kanta Jamil, *Ph.D* and Zareen Khair, *Ph.D* in designing and preparing report. From the beginning to end Dr. Quamrun Nahar was involved closely and provide extended support to make it a useful report. Also our sincere thanks to the adolescent respondents and their parents for their valuable time and information for the survey.

Mohammad Shahjahan
Director & CEO, BCCP

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Finally, we remain grateful to the young people who gave their valuable time so that we could interview them.

Haidary Kamal
Executive Director
ACPR

GLOSSARY

ACPR	Associates for Community and Population Research
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal Care
ARH	Adolescent Reproductive Health
AWG	Adolescent Working Group
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BCCP	Bangladesh Center for Communication Programs
BDHS	Bangladesh Demographic and Health survey
BRAC	Bangladesh Rural Advancement Committee
CPS	Contraceptive Prevalence Survey
CWFD	Concern Women for Family Development
HIV	Human Immunodeficiency Virus
HPSP	Health and Population Sector Program
NIPHP	National Integrated Population and Health Program
OMI	Organization for Mothers and Infants
PNC	Post-natal Care
QCO	Quality Control Officer
RH	Reproductive Health
SARHI	Survey of Adolescent Reproductive Health Interventions
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TT	Tetanus Toxid
TV	Television
UFHP	Urban Family Health Partnership
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Adolescent Reproductive Health (ARH) is a relatively new area of health intervention in Bangladesh. Although adolescent population constitutes a significant part of the total population of the country, they were yet to be considered a priority sub-population in reproductive health system among policy makers in Bangladesh, until recently. Consequently adolescents face various obstacles in accessing the services, one of which is receiving accurate information regarding reproductive and sexual health. In addition, adolescents are often not aware of adolescent-friendly sources of care, which when combined with their limited knowledge hinders their ability to make informed choices to protect and promote their own well-being. However, the recent threat of HIV epidemic along with international pressure from various UN organizations the government and some NGOs have come up with programs for strengthening ARH. Under the supervision of the Bangladesh Center for Communication Programs (BCCP), a media intervention programme has been planned to improve adolescent reproductive health. To monitor and evaluate the impact of adolescent reproductive health intervention the Baseline Survey of Adolescent Reproductive Health Intervention was conducted from 11 January to 12 March 2002 to establish benchmark status of the extent to which adolescents have contact with major media outlets, their knowledge about a range of reproductive health issues, and their access to reproductive health information and services.

Methodology

The 2002 baseline survey employed a nationally representative, two-stage sample. Married and unmarried male and female adolescents aged 13-19 years from rural and urban areas constituted the respondent groups. A total of 3686 adolescents were interviewed from 200 clusters (80 urban and 120 rural), randomly selected from BDHS 1999-2000 sample clusters. Using household listing data of the selected clusters four frames were prepared: married male, married female, unmarried male and unmarried female for adolescents aged 13-19 separately for urban and rural areas. A systematic sample of adolescents was then selected from each of the frames except married male groups of urban and rural areas from which all available ones were selected for interview. Only one adolescent from a household was selected for interview. As the sample was not self-weighted, weighting factors (considering different selection probabilities for males and females, married and unmarried adolescents' sample) were applied to the data to obtain the overall national estimate. Data were collected by interviewing randomly selected adolescents using a structured questionnaire.

Respondents' profile

From household listing data it was found that 26.8 percent of female adolescents and 2.2 percent of male adolescents aged 13-19 were ever married. About one-tenth of both male and female adolescents covered in the study did not have any formal education. Adolescents with secondary or higher level of education were higher in proportion in urban areas than in rural areas, while

proportions with no education or with primary education were higher in rural areas. About 47 percent of the males and 10 percent of the females were currently working. The proportion of females working for money was somewhat higher in urban areas. It is interesting to note that female adolescents were consistently poorly paid in both rural and urban areas.

Media exposure

Radio, television, newspaper/magazines, videos, and booklets are considered important sources for providing information about ARH. Respondents were asked whether they listen to radio, watch television or video, and read newspaper/magazines or any booklets containing reproductive health information. It was found that television viewer-ship among adolescents is quite high (77.8 percent). Among adolescents, significantly higher proportion of urban (94.4 percent) than rural (73.9 percent) adolescents reported viewing TV. On the other hand, exposure to radio was 51.3 percent with higher exposure in rural areas (56.4 percent) compared to urban areas (29.9 percent). More males than females listened to the radio. Exposure to newspapers/magazines (24.5 percent) and booklets (4.3 percent) was low.

Only 18.2 percent of adolescents interviewed were found every day listeners and Friday was the preferred day for listening to radio programs.

Only 8.4 percent of all adolescents and 16.4 percent of radio listeners listened to the BCCP sponsored radio program *Jante Chai Janate Chai* although it was specially designed for adolescents and meant to give them necessary information about behavioral changes. It may be mentioned here that the program has been in air since August 2001, which means, exposure to the program reflects the impact of the program coverage for only a few months. Nevertheless, almost all listeners who reported to listen to them found the program entertaining and informative.

Nearly one-third (27.2 percent) of the adolescents were everyday viewers of TV. Friday (94 percent) and Thursday (67.4 percent) were preferred days for viewing television.

Awareness and exposure to some important RH related media messages about HIV/AIDS, postponing early marriage, family planning, and ANC/PNC is relatively high among both male and female adolescents. TV and radio seem to be the main sources of these information. However, awareness or exposure to certain messages like physical changes during puberty, and signs and symptoms and knowledge about transmission and prevention of STIs do not seem to be encouraging.

Attitude and practices regarding marriage, fertility and family planning

The reported ideal age at marriage for girls is in line with the legal age for marriage (18 years). The stated ideal age at marriage for an adolescent male is about 24 years which is well above the legal age (21 years). The stated mean ideal age for females for having the first child varied from 21.4 years to 22.3 years. About 72 percent of male adolescents and 68 percent of females viewed 25 years or more as the appropriate age for a male to become a father.

However, about 17 percent of all female adolescents (respondents and non-respondents) aged 13-19 were found ever pregnant with a higher proportion in rural areas (19.4 percent) compared to urban areas (13.9 percent).

The percentage of pregnant females among currently married adolescents aged 15-19 at the time of the survey was 16.6 percent compared with 14.7 percent in the 1996-97 BDHS and 15.9 percent in the 1999-2000 BDHS, showing a slight upward trend.

Most female adolescents were in favour of limiting the family to two children (74 percent). The ideal spacing between two births, as reported by the adolescents interviewed is generally long (3.0 years by the male and 3.98 by the female).

Of the married females, about 41 percent were current users of a modern family planning methods, which is slightly higher than the corresponding BDHS 1999-2000 reported rate. The pill continues to be by far the most popular method (25 percent) and pharmacies the main sources of contraceptive supply.

Knowledge about STIs including HIV and condom use

Awareness of HIV/AIDS seemed to be quite high amongs adolescents (73.1 percent among females and 83.2 percent among males). Knowledge of adolescents regarding HIV/AIDS is found higher compared to their older counterparts as reported in BDHS 1999-00. Among those who were aware of HIV/HIDS, large majority (84.5 percent of males and 73.9 percent of females) were able to provide at least two correct answers about modes of transmission of HIV/AIDS. Among them knowledge about ways of avoiding HIV/AIDS also seems to be quite high; 85.5 percent of males and 70.3 percent of females could mention at least two correct ways of preventing AIDS. Television and Radio appear to be the two main sources of information about HIV/AIDS.

However, awareness of STIs other than HIV/AIDS is quite low. Only 5.2 percent of males and 4 percent of females know of other STIs. Awareness of correct symptoms, modes of transmission and, ways to prevent STIs is even lower.

Knowledge of male adolescents about various use of condoms is reasonably high. About four-fifths of males know condom as a contraceptive method, while 61 percent know condom as both family planning method and a preventive measure of STI/AIDS. However, knowledge of female adolescents regarding other uses of condoms, other than FP method, is low. Only 38 percent of females could mention condoms as both FP method and a preventive measure of STI/AIDS.

Preferred source of information about RH issues

Respondents were asked that whether they ever discussed with others anything about the changes they experienced during puberty. About 42 percent of the males and 69 percent of the female adolescents discussed with others about the physical changes they experienced during puberty. About 61 percent of married females against 51 percent of married males discussed about conception with others. Friends/peers seemed to be preferred persons for discussions about RH issues. A negligible proportion reported discussing the matter with health personnel.

Friends/relatives and health personnel were the two main preferred sources of information about RH issues.

Conclusion

Based on the findings and experience of the baseline study, the following program strategies have been identified:

i. Exposure to TV among all adolescents and exposure to radio among rural adolescents is quite high. This fact should be taken into consideration in planning ARH media intervention.

ii. Awareness of HIV/AIDS, its modes of transmission and prevention among adolescents is quite high, but knowledge and awareness of other sexually transmitted infections, their symptoms and modes of transmission is very low. Specially designed media programs to increase awareness about STIs other than AIDS are therefore recommended.

iii. Condoms as a method of contraception and condoms as a device of prevention of HIV/AIDS were known to four-fifths of the adolescents interviewed. However, a significant proportion of the adolescents surveyed, did not know dual preventive role of condoms -- an effective device for FP method as well as a preventive measure for STI/AIDS. Moreover, the females were less aware of condom use than the males. More initiatives to inform adolescents regarding use of condom is thus required.

Chapter 1

INTRODUCTION

1.1 Background

In Bangladesh adolescents aged 10-19 years comprise about 25 percent of the total population (BDHS 1999-2000). Adolescence is a difficult period for most young people as they attempt to cope with decisions regarding marriage, fertility, education and work, establishment of their identities and places in the society. Moreover, adolescence is also a time during which they form some habits that endure throughout their lives.

The needs and concerns of adolescents in Bangladesh are similar to those of their counterparts elsewhere, although their circumstances are often quite different. Bangladesh is a developing country with limited resources, and faces numerous problems such as overpopulation, illiteracy and natural disasters. Even within the country, adolescents are not a homogenous group and various social, cultural and economical differences exist amongst them.

Bangladesh society is conservative and various gender inequalities exist in it. Early marriage and early pregnancy are the norms. About 48 percent of all 15-19 year old girls are married and the median age of first birth is 17 to 18 years (BDHS 1999-2000). Talking about reproductive health or sexuality is embarrassing for most people. In such an environment, it is difficult for adolescents to obtain reproductive health related information or the services.

1.2. Adolescent reproductive health BCC programs

Considering the significance of adolescent and their social and psychological vulnerability relating to health, adolescent reproductive health has received attention in the health programs of the country. Previously, health needs of married women of reproductive age only was prioritized, as they were considered to be at higher risk for higher rate of maternal mortality.

Evidence suggests that while a number of organizations initiated pilot projects in the country in the past, most of these programs were very service-oriented which did not take into account of adolescents' perspectives. This indicates a need for systematic research on identifying adolescent reproductive health needs and designing programs targeting those needs. Although a number of organizations adopted programs for adolescents there was inadequate documentation and evaluation of such programs. Therefore, promoting particular strategies or activities for large-scale implementation was impossible.

In 2001 the Family Health Research Project (FHRP) (former Operations Research Project) of ICDDR,B initiated a program to provide adolescents with accurate and accessible information on reproductive and sexual health. After talking to a large number of adolescents, FHRP developed a databank that contained a large number of questions about reproductive health that they wanted

to have answered. USAID then initiated the process of making the best use of the databank by forming a working group with members from BCCP, FHRP, ICDDRB and NIPHP service delivery partners. The group was then expanded with members from BRAC, UNICEF, UNFPA, the Marie Stopes Clinic Society, UNAIDS and the Population Council, FHI, Save the Children (USA) and the Government of Bangladesh. It was decided that a package of BCC materials would be developed addressing the reproductive health needs for adolescents under the leadership of BCCP. The idea was to focus the similar items from different directions. Thus the BCC materials developed were:

(i) A set of booklets answering the questions of the data bank regarding basic information about reproductive health. These booklets cover topics relating to physical and emotional changes during puberty, marriage and family health, including conception, family planning, maternal and child health, risky behavior leading to HIV/AIDS and other STIs/RTIs and discuss human relationships and sexuality. In total, there are four booklets of this type named '*Nijeke Jano'*.

(ii) A four-part video series designed in the form of variety TV format of 26 minutes each. The videos cover most of the same topics covered by the booklets.

(iii) A 52-episode special radio program '*Jante Chai Janate Chai'* developed exclusively for adolescent boys and girls to help them learn to look after their physical health as well as to help them develop morally and acquire an appositive outlook on life. The serial deals with changes in reproductive health during adolescence, cautions against early marriage and pregnancy, and provides information on safe delivery. It also discusses sexual harassment, teaches boys to treat women with respect, and promotes STI/AIDS awareness and adoption of proper behavior with AIDS patients.

(iv) A set of other supportive materials that include magazines and brochure for parents.

1.3 The baseline survey

To monitor and evaluate the impact of adolescent reproductive health intervention designed to improve adolescent reproductive health status a baseline survey was conducted. The survey aimed to establish the benchmark status of the extent to which adolescents have contacts with major media outlets, their knowledge about a range of reproductive health issues, and the extent to their access to reproductive health information and services. The baseline survey is unique in that no previous studies have been undertaken in Bangladesh that directly focused on adolescents' contact with different media sources.

1.4 Objectives of the baseline study

The specific objectives were to:

- Assess the extent to which adolescents aged 13-19 have contact with major media outlets such as radio, television, newspapers, magazines, booklets and videos.

- Measure the extent to which adolescents have heard about and understand a range of reproductive health issues such as *postponing age at marriage, menstruation and wet dreams*, *how pregnancy occurs, family planning/contraception, how to prevent HIV/AIDS, how to prevent other sexually transmitted diseases, use of condoms, and where to obtain reproductive health care.*

- Assess exposure to ARH BCC programs through different media, namely the radio program, booklets and video programs.

- Assess views about and attitudes of adolescents regarding age at marriage, age at child bearing and birth spacing.

- Assess practice of family planning and antenatal care among married adolescents.

- Measure adolescents' awareness and knowledge of HIV/AIDS and other sexually transmitted diseases (STIs) with focus on whether adolescents know about sources of infection, common symptoms, prevention and places to obtain STD care;

1.5 Organization of the report

In addition to the introduction, this report has six more chapters. The second chapter highlights the methodology used for the survey. In particular, it describes the sampling, data collection techniques, data analysis and problems encountered in the study. Chapter Three gives some background characteristics of the respondents. Chapters Four to Six present the main study findings. It may be mentioned here that the survey did not collect information on all aspects of adolescent reproductive health. References to available information on certain key aspects of adolescent reproductive health from other recent studies have been made where possible. The final chapter discusses main study findings with particular reference to current BCC programs and highlights some key indicators which need to be followed to measure the success of ARH BCC activities.

Chapter 2

METHODOLOGY

The 2002 survey is a baseline study to assess the benchmark status of Adolescent Reproductive Health (ARH) at the onset of USAID's BCC/Communication campaign to improve adolescents' reproductive health knowledge, attitudes and practices. Married and unmarried male and female adolescents aged 13-19 from rural and urban areas constituted the respondent groups.

2.1 Sample design

Since one of the objectives of the survey is to provide separate estimates for married and unmarried male and female adolescents by urban and rural areas, the survey used sex-marital status and residence stratified sampling for selecting the study sample.

Bangladesh is divided into 6 administrative divisions, 64 districts and 490 upazilas. In rural areas, upazilas are divided into Unions and then Mauzas. Urban areas are divided into Wards and then Mahallas. The 2002 baseline survey employed a nationally representative, two-stage sample that was selected from the master sample, Sample Vital Registration System (SVRS), maintained by the Bangladesh Bureau of Statistics (BBS) for the implementation of surveys. The SVRS consists of 500 primary sampling units (PSUs) both in urban and rural areas (320 units in rural and 180 in urban areas). In the rural areas, the PSU is a Mauza, while in the urban areas, it is a Mahalla, consisting approximately of 250-350 households. The PSUs in the SVRS are selected with probability proportional to size (PPS) from the 1991 census frame. In the survey, units were sub-selected with equal probability (simple random method) so that the selection procedure is equivalent to selection with probability proportional to size. A total of 200 primary sampling units were used for the survey, taking 80 from urban areas and 120 from rural areas.

Associates for Community and Population Research (ACPR) conducted a household listing operation in a randomly chosen segment of around 80 households in each of the selected sample points of urban and rural areas from February to March 2002. A household questionnaire containing household information such as names of household members, marital status, age, etc. was used. Using the household listing data, four frames were prepared: married male, married female, unmarried male and unmarried female for adolescents aged 13-19 separately for urban and rural areas. A systematic sample of adolescents was then selected from each of the frames except married male groups of urban and rural areas from which all available ones were selected for interview. Only one adolescent from a household was selected for interview. As the sample was not self-weighted, weighting factors (considering different selection probabilities for married and unmarried adolescents sample) were applied to the data to obtain the overall national estimates.

2.2 The questionnaires

Bangladesh Center for Communication Programs (BCCP) provided draft household and individual respondent questionnaires, which were developed in collaboration with the Adolescents Reproductive Health Working Group. A household questionnaire was used for household enumeration and a respondent questionnaire for interviewing adolescents. The questionnaires designed were developed in English and then translated into and printed in Bangla. A copy of the questionnaire designed for the survey of Adolescent Reproductive Health Intervention is given in Appendix A.

The questionnaire was pretested on parallel groups of respondents to ascertain the flow of sequence of the questions, the suitability of the language, the appropriateness of the skip instructions, and the comprehensiveness of the issues to address the objectives of the study. On the basis of the pretest results, the questionnaire was modified and finalized for data collection.

The household questionnaire was used to list all the usual members in the selected households. Some basic information was collected on the characteristics of each person listed, including his/her age, sex and education. The main purpose of the household questionnaire was to identify married and unmarried adolescents for preparing sampling frames in order to select eligible respondents for interviews.

The respondent's questionnaire was used to collect information from married and unmarried adolescents aged 13-19 years. Prior to interviewing adolescents, informed consent was obtained from parents/guardians and the responding adolescents. The adolescents were asked questions in the following areas:

- Background characteristics (age, religion, education, employment, etc.).
- Media contact (frequency of listening to the radio, and viewing TV, exposure to newspapers and other media, timing of contact, types of programmes, etc.).
- Attitudes toward marriage and pregnancy.
- Fertility preference and current use of family planning methods.
- Sexual and reproductive health.
- Knowledge of HIV/AIDS and STDs.

2.3 Training and data collection

The questionnaire was pretested in 21-27 December 2001. For the pretest, male and female interviewers were trained at the training venue of ACPR. The pretest team conducted interviews in urban and rural locations under close supervision of the project team. Based on observations in the field and suggestions made by the pretest teams, necessary modifications were made in the questionnaire.

An intensive training for the data collectors for a period of 10 days was carried out at the start of the survey. The survey was carried out deploying 10 teams, each comprising of two female and

one male interviewers, one male and one female supervisors and a male field assistant. ACPR also fielded three teams (each consisting of a male and a female) of quality control officers (QCOs) for ensuring quality of data. Each data collector had a graduation degree as a minimum qualification. After intensive training, the teams were deployed for data collection. Training for the data collectors was conducted in 26 December 2001 to 10 January 2002. The training schedule included two days of field practice.

Data collection for the survey was conducted between 11 January to 12 March 2002. Fieldwork was implemented in two phases. In addition to QCOs, senior members of the study team, and BCCP personnel monitored the data collection by visiting teams in the field. A list of personnel who participated in the study is given in Appendix B.

2.4 Data processing

Data processing was done at ACPR. All the questionnaires for the baseline survey were returned to Dhaka for data processing at ACPR. The processing operation consisted of office editing, coding of open-ended questions, data entry and editing inconsistencies found by the computer programs. A data entry package was developed using Foxpro in accordance with the data collection instruments. The data were processed on microcomputers commencing on 03 February 2002 and the processing was completed by 21 March 2002. For compiling national estimates USAID/MACRO International supplied BDHS 1999-2000 sample weights were used. Packages such as SPSS and SAS were used for data analysis. Data are presented using univariate and bivariate tables and appropriate graphs have been used to highlight important findings.

2.5 Response rates

A total of 4728 eligible adolescents were selected for the sample, of whom 3686 were successfully interviewed. The overall non-response rate was approximately 22 percent (Table 2.1). The shortfall occurred primarily due to failure to find the respondent at home despite repeated visits to the households. Non-response was much higher among males compared to females. It was also higher in the urban sample than in the rural sample.

A total of 130 married male adolescents aged 13-19 could be identified in the sample frame, but only 70 of them were available for interview, resulting in a response rate of 53.8 percent. The response rate among unmarried males was 77.5 percent. A total of 1632 eligible unmarried females and 1327 eligible married females were selected for the interview, the corresponding response rates were 80.5 and 77.8 percent. The overall response rate was 78 percent.

Table 2.1: Results of the household and individual interviews and response rates

Respondents	Rural	Urban	Total
Male Unmarried			
Selected	708	931	1639
Successfully interviewed	561	709	1270
Response rate	**79.2**	**76.2**	**77.5**
Male married			
Selected	91	39	130
Successfully interviewed	49	21	70
Response rate	**53.8**	**53.8**	**53.8**
Female Unmarried			
Selected	706	926	1632
Successfully interviewed	572	742	1314
Response rate	**81.0**	**80.1**	**80.5**
Female married			
Selected	747	580	1327
Successfully interviewed	599	433	1032
Response rate	**80.2**	**74.7**	**77.8**
Overall			
Selected	2252	2476	4728
Successfully interviewed	1781	1905	3686
Response rate	**79.1**	**76.9**	**78.0**

2.6 Limitations of sample profile

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

(i) Parents of adolescent respondents were in general suspicious and reluctant to have their sons/daughters interviewed. Refusal by parents and respondents contributed to non-response in some cases.

(ii) Instead of maintaining secrecy, some respondents disclosed the subject matters of the interviews to their parents and others. Consequently, the interviewers faced angry reactions and unpleasant situations in subsequent interviews.

(iii) Non-response rate due to unavailability and refusal to respond was very high, especially for married respondents. This resulted in limiting analysis in some cases by married-unmarried classification.

(iv) Analysis by married-unmarried classification (for certain variables) could not be done because of very small number of cases reported particularly in the married male group.

Chapter 3
CHARACTERISTICS OF RESPONDENTS

This chapter presents some selected socio-economic characteristics such as age, education, sex, religion, school enrollment, income and working status of sample adolescents. This information on the characteristics of adolescents interviewed was essential for the interpretation of survey findings.

Information was collected from households regarding age, sex and marital status of all household members to prepare sampling frames for married and unmarried adolescents by male-female classification. Table 3.1 gives the percentage of married adolescents by age and sex. It shows that among female adolescents aged 13-19 years 26.8 percents was ever-married. The corresponding proportion for male adolescents was 2.2 percent.

Table3.1: Adolescents' marital status
Percentage of ever-married male and female adolescents in all households covered in the household listing, according to age.

Age	Male		Female	
	Ever married	N	Ever married	N
13	0.2	903	1.7	984
14	0.2	962	4.3	967
15	0.1	985	10.3	920
16	0.8	872	21.9	963
17	1.6	705	33.3	972
18	4.2	1179	51.9	1297
19	10.5	584	65.3	749
Total	2.2	6208	26.8	6552[1]

3.1. Age, sex and residence

Table 3.2a shows the distribution of male and female adolescents by selected background characteristics. To assess age, respondents were asked – *In what month and year were you born*? and *how old were you on your last birthday*? The interviewers were trained to probe in situations in which respondents did not know their age or date of birth, and were instructed as a last resort to record the best estimates of the respondent's age. The age distribution by single-year age groups from 13 to 19 years of age by male-female and rural-urban classification was found almost similar. The mean age of the respondents was 15.7 years.

The distribution of respondents by division of residence shows that nearly one-third (31.9 percent) of the respondents live in Dhaka Division, one-fifth (20.3 percent) in Rajshahi Division, and another one-fifth (20.5 percent) in Chittagong Division. About 13 percent of the respondents

[1] The number includes all adolescents, either respondent or non-respondent, of all households covered in the household listing.

live in Khulna Division, 7.6 percent in Barisal Division, and 7.2 percent in Sylhet Division.The age distribution of male and female by urban and rural classification was found to be similar. Nearly nine in every ten (86.7 percent) respondents were Muslims, while the rest were mostly Hindus.

Table 3.2a: Background characteristics of respondents
Percentage distribution of male and female respondents by age, residence, education and, enrolment status

Background Characteristics	Rural			Urban			National		
	Male	Female	All	Male	Female	All	Male	Female	All
Age:									
13 Yrs.	14.3	17.1	15.7	11.5	15.9	13.8	13.8	16.8	15.3
14 Yrs.	17.0	16.8	16.9	13.4	18.6	16.1	16.4	17.1	16.8
15 Yrs	16.0	19.2	17.6	20.3	17.4	18.8	16.8	18.8	17.9
16 Yrs	18.2	15.5	16.8	13.7	13.9	13.8	17.4	15.2	16.2
17 Yrs	12.7	12.1	15.4	16.9	10.5	13.5	13.4	11.8	12.6
18 Yrs	14.7	11.6	13.1	12.1	14.4	13.3	14.2	12.1	13.2
19 Yrs	7.1	7.8	7.4	12.1	9.4	10.6	8.0	8.1	8.0
Mean age	15.7	15.5	15.6	16.0	15.7	15.8	15.7	15.6	15.7
Division:									
Barisal	9.0	8.5	8.7	2.7	2.7	2.7	7.8	7.3	7.6
Chittagong	22.3	21.5	21.9	14.4	14.5	14.4	20.9	20.1	20.5
Dhaka	33.4	32.1	32.7	28.3	28.3	28.3	32.5	31.3	31.9
Khulna	15.1	12.5	13.8	8.0	7.1	7.5	13.8	11.4	12.6
Rajshahi	12.7	16.0	14.3	44.8	45.6	45.2	18.5	22.0	20.3
Sylhet	7.6	9.3	8.5	1.7	1.9	1.8	6.5	7.8	7.2
Religion:									
Islam	85.3	85.3	85.3	92.4	92.8	92.6	86.6	86.8	86.7
Hinduism	12.4	12.2	12.3	7.3	7.0	7.1	11.4	11.2	11.3
Others	2.4	2.4	2.4	0.3	0.2	0.2	2.0	2.0	2.0
Education level:									
No education	11.5	11.2	11.3	5.3	5.4	5.4	10.4	10.0	10.2
Primary incomplete	21.7	19.2	20.5	13.8	11.7	12.7	20.3	17.7	19.0
Primary complete	14.6	15.5	15.0	10.0	8.9	9.4	13.7	14.2	14.0
Secondary incomplete	45.0	48.9	46.9	49.9	55.0	52.6	45.9	50.1	48.0
Secondary +	7.2	5.3	6.2	21.0	18.9	19.9	9.7	8.0	8.9
School enrollment									
Currently in school	47.0	43.7	45.3	64.5	62.9	63.6	50.2	47.6	48.9
N (weighted)	1479	1494	2974	332	380	712	1812	1874	3686
N (unweighted)	610	1171	1781	730	1175	1905	1340	2346	3686

3.2. Education

About 10.2 percent of the adolescents interviewed never attended school, 33.0 percent attended or completed primary education, and the remaining 56.8 percent had some secondary or higher level of education. Respondents having secondary or higher level education were higher in

proportion in urban areas (72.5 percent) than in rural areas (53.1 percent), while proportions with no education and with primary education were higher in rural areas. No significant differences could be seen between the education levels of male and female respondents within urban or rural areas.

Substantial rural-urban variation was observed in the current schooling status of the adolescents interviewed. About 63.6 percent of the urban adolescents interviewed were currently attending school against 45.3 percent of the rural adolescents. Some variations in current schooling status also existed between males and females for both rural and urban adolescents. About 50.2 percent of the male adolescents were currently attending school compared to 47.6 percent among female adolescents.

3.3. Income and working status

The survey collected information from adolescents on their current working status. Table 3.2b shows that 29.0 percent of rural and 25.2 percent of urban adolescents were currently working. Significantly higher proportion of males than females were found working among both rural (49.6 percent males vs. 8.6 percent females) and urban (37.1 percent males vs. 14.7 percent females) adolescents. Proportion of female adolescents who were working was almost double in urban areas compared to rural areas.

Those who were not currently working were asked whether they had worked in any jobs in the last six months prior to the survey. Only about 3.5 percent responded in the affirmative. Sixty-nine percent were found not currently working and had not worked in the last six months. Among the types of jobs they were doing, agricultural work, factory work/blue colour service, semi-skilled labour, own business and home-based manufacturing, poultry or cattle rearing were the main ones.

Substantial difference in mean income was observed between male and female adolescents. Female adolescents were significantly paid lower wages (mean income 581 taka) compared to their male counterparts (mean income about 1370 taka). However, no rural-urban variation in the income pattern was observed.

Table 3.2b: Background characteristics of respondents
Percentage distribution of male and female respondents by working status and income

Background Characteristics	Rural			Urban			National		
	Male	Female	All	Male	Female	All	Male	Female	All
Working status:									
Currently working	49.6	8.6	29.0	37.1	14.7	25.2	47.3	9.8	28.3
Currently not working but worked in last 6 months	4.0	1.7	2.8	2.7	2.1	2.4	3.7	1.8	2.7
Not working and did not work in last 6 months	46.4	89.7	68.2	60.2	83.2	72.5	48.9	88.4	69.0
N (weighted)	**1479**	**1494**	**2974**	**332**	**380**	**712**	**1812**	**1874**	**3686**
Type of jobs involved in:									
Agricultural worker/ Farmer/ Fisherman	38.6	12.5	34.4	7.5	-	5.1	34.1	8.9	29.3
Rickshaw puller/ Boatman	3.7	-	3.1	4.2	-	2.8	3.8	-	3.1
Domestic servant	1.4	9.1	2.6	2.4	12.2	5.6	1.5	10.0	3.2
Factory worker/Blue collar service	26.5	10.3	23.9	38.5	32.0	36.4	28.2	16.6	26.0
Home-based manufacturing/Poultry/ Cattle raising	0.9	40.5	7.3	2.4	27.2	10.5	1.1	36.6	7.9
Construction work	2.4	-	2.0	1.3	-	0.9	2.3	-	1.8
Own business	13.3	7.3	12.3	13.5	1.0	9.5	13.3	5.5	11.8
Semi-skilled laborer	11.8	9.0	11.3	24.5	6.9	18.7	13.6	8.4	12.6
Others (Professional worker, BRAC school teacher)	1.3	11.3	3.0	5.8	20.7	10.7	2.0	14.0	4.3
Monthly income:									
Tk. <500	11.8	61.8	19.9	16.2	50.8	27.4	12.4	58.6	21.2
Tk. 500-999	21.8	20.9	21.7	21.8	24.7	22.7	21.8	22.0	21.8
Tk. 1000-1999	44.4	13.4	39.4	37.5	16.5	30.7	43.4	14.3	37.9
Tk. 2000-2999	14.3	3.9	12.6	14.5	6.3	11.8	14.3	4.6	12.5
Tk. 3000+	7.7	-	6.5	10.1	1.7	7.4	8.1	0.5	6.6
Mean	1359	537	1225	1437	686	1193	1370	581	1220
N (weighted)	**793**	**154**	**946**	**132**	**64**	**196**	**925**	**217**	**1143**

Chapter 4

MEDIA EXPOSURE AND EXPOSURE TO REPRODUCTIVE HEALTH RELATED INFORMATION

Media may play an important role in communicating messages about various issues related to health, family planning and other important issues. As one of the major components of ARH intervention is dissemination of RH messages among adolescents through the mass media, this section attempts to examine the status of the extent to which adolescents have contact with major media outlets viz. TV, Radio, Print media and Video. An attempt was also made to examine the exposure of adolescents to selected reproductive health related (RH) information and to assess the contribution of different types of media in generating awareness of RH issues.

4.1 Exposure to media

It is important to know through which medium of mass communication the target population can be reached most effectively for the purposes of planning programs intend to disseminate information about reproductive health. Understanding of the exposure adolescents have to different types of media is thus essential.

Respondents were asked whether they listen to radio, watch television or video, and read newspapers/magazines or any booklets containing reproductive health information. The reach or exposure to radio, television or video, newspaper/magazines and booklets was defined as the percentage of respondents who listened to/watched radio/TV or read newspaper/magazine/ booklets.

Figure 4.1 gives the percentage of adolescents by exposure to different media. Exposure to TV was found to be the highest (77.8 percent) among adolescents, followed by radio (51.3 percent), and newspaper/magazine (24.5 percent). Very few of the adolescents (4.3 percent) interviewed had read booklets containing information related to reproductive health and only about one percent had ever watched videos. About 86 percent of adolescents had exposure to at least one of these media.

Figure 4.1 : Percentage of adolescents by exposure to different media

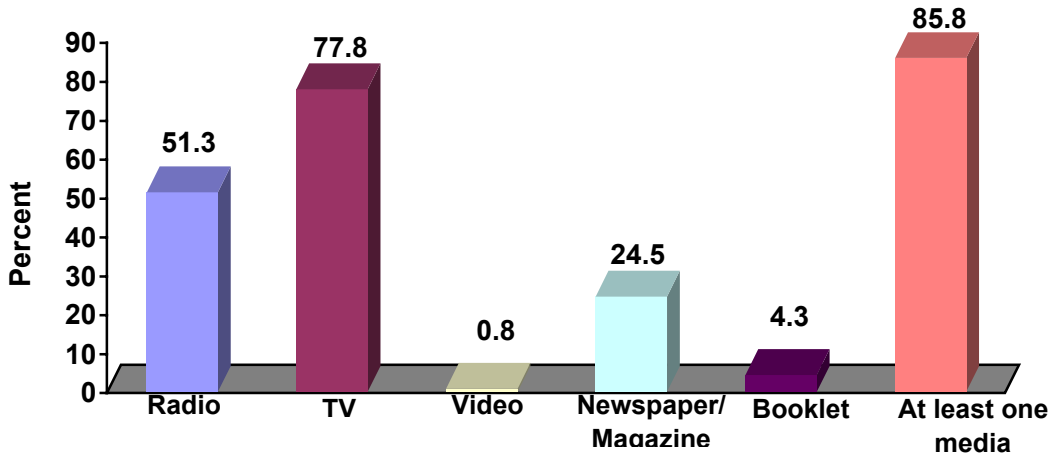


Table 4.1 gives the differentials in the exposure of adolescents to different media by selected background characteristics. It is evident that media reach was higher among males than females. Nearly 92 percent of males against 80.2 percent of females were exposed to at least one media. Media exposure was higher among unmarried (88.4 percent) than married (70.9 percent) adolescents.

Table 4.1 Media exposure
Percentage of adolescents exposed to different types of mass media by selected background characteristics

Background characteristics	Exposure to							
	No Media	Radio	TV	Video*	Newspaper/ Magazine	Book/ Booklet	At least one media	N
Sex:								
Male	7.4	59.2	87.2	0.7	32.4	4.0	91.6	1812
Female	19.8	43.6	68.8	0.9	16.9	4.7	80.2	1874
Marital status:								
Married	29.1	40.1	55.5	0.5	5.9	4.5	70.9	556
Unmarried	11.6	53.3	81.8	0.9	27.8	4.3	88.4	3130
Residence:								
Urban	4.0	29.9	94.4	0.3	37.1	2.9	96.0	712
Rural	16.7	56.4	73.9	1.0	21.5	4.7	83.3	2974
Education:								
No education	33.7	32.8	57.0	0.5	0.1	0.2	66.3	376
Primary incomplete	28.5	40.1	64.0	0.0	2.7	0.0	71.5	699
Primary complete	15.4	55.4	72.9	1.0	14.3	2.2	84.6	514
Secondary +	5.7	57.3	87.4	1.1	38.6	7.0	94.3	2097
Working status:								
Currently working	13.8	55.9	81.3	1.0	19.3	3.8	86.2	1042
Currently not working	14.4	49.4	76.5	0.8	26.6	4.5	85.6	2644
School enrollment:								
Currently enrolled	6.8	56.2	87.2	1.3	39.5	6.5	93.2	1799
Currently not enrolled	21.3	46.6	68.9	0.4	10.2	2.3	78.7	1887
All	**14.6**	**51.3**	**77.8**	**0.8**	**24.5**	**4.3**	**85.8**	**3686**

Adolescents having some primary, secondary, or higher education are more likely to be exposed to different media compared to those having no education. About 94.3 percent of secondary and higher level educated and 84.6 percent of primary level educated had exposure to at least one media against 66.3 percent of those having no education.

Currently working adolescents had more exposure to media than non-working adolescents. Media exposure was also higher among currently school-enrolled adolescents than non-enrolled ones irrespective of the types of media accessed.

4.2 Reaches of radio

Radio is an important medium of mass communication. Through radio a target group can be reached very easily. Majority of adolescents (51.3 percent) of Bangladesh listens to radio. Radio-reach was almost two times higher among rural respondents (56.4 percent) compared to urban respondents (29.9 percent) (Figure 4.2). Males (59.2 percent) are more likely to listen to this medium than females (43.6 percent). A substantially higher proportion of educated adolescents listen to radio than those having little on no education (Table 4.1). However, there are marked variations between male and female listeners in rural areas (not shown).

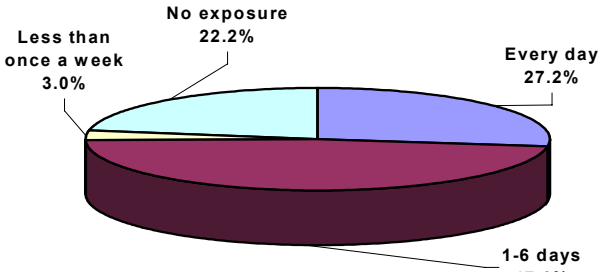
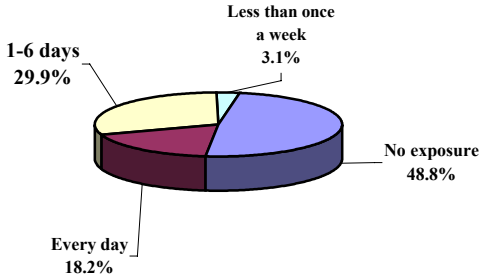


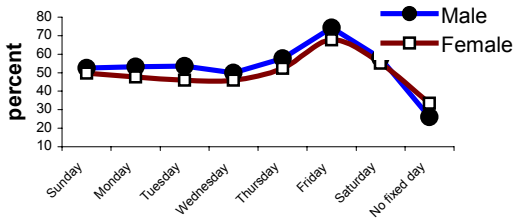
Figure 4.3a: Percentage distribution of respondents by frequency of listering radio



Only 18.2 percent of the adolescents interviewed stated that they listened to the radio every day, 29.9 percent said that they listened 1-6 days a week, and 3.1 percent reported that they listened less than once a week (Figure 4.3a). Every day radio listener among adolescents are more in rural areas (20.4 percent) than in urban areas (9.1 percent). Males are more likely to listen to radio programs every day compared to female adolescents (Table C4.1 in Appendix).

Figure 4.3b Percentage of radio listeners by day of listening

Percentage of radio listeners by specific days of the week can be seen in Figure 4.3b As expected, the listeners reported that they were more likely to listen to radio on Friday, the weekend. More than 70 percent of radio listeners, both males and females, stated that they listen to the radio on Friday compared to 48 to 57 percent on any other weekdays. Almost one-third (29.3 percent) of the adolescents interviewed said that they had no fixed day for listening to the radio. Male-female and urban-rural variations in this respect seems to be not significant. Of those adolescents who identified themselves as radio listeners, 67.1 percent listened to programmes in their homes, and 25.6 percent listened at relatives/neighbors houses (Table C4.1 in Appendix).



Listenership of the Radio Program *Jante Chai Janate Chai*

Information was collected to ascertain reaches of the BCCP sponsored adolescent focused radio program *Jante chai Janate chai*. At the time of the survey, only 14 episodes of the program were aired. Table 4.2 gives percentage of adolescents and radio listeners among adolescents who heard the radio program *Jante chai Janate chai* by selected background characteristics. It shows that only 8.4 percent of all adolescents and 16.4 percent of radio listeners had listened to the program. Listenership is a little higher among female (18.9 percent) than male (14.4 percent) listeners. There is no variation in the listenership of the program between rural and urban radio listeners. Differentials in listenership of the program by level of education and working status seems to be not much wide. Most of the listeners of the program found the program informative and entertaining.

Table 4.2 Exposure to radio serial 'Jante Chai Janate Chai'
Percentage of adolescents and radio listeners among adolescents who heard the radio serial 'Jante Chai janate Chai' by selected background characteristics.

Background characteristics	Among all adolescents		Among radio listeners	
	%	n	%	n
Sex				
Male	8.6	1812	14.4	1073
Female	8.2	1872	18.9	815
Marital Status				
Married	6.7	556	16.6	223
Unmarried	8.7	3128	16.3	1665
Residence				
Urban	4.9	712	16.4	213
Rural	9.4	2972	16.3	1676
Education				
No education	5.6	378	16.8	125
Primary	5.4	1214	11.7	566
Secondary	10.6	1766	18.8	1023
SSC and above	10.4	327	19.5	174
Working Status				
Working	8.7	1042	15.6	583
Not working	8.3	2642	16.7	1305
All	**8.4**	**3684**	**16.4**	**1888**

4.3 Viewership of television and video

Television (TV) is widely considered to be the most effective and entertaining mass media. Viewership of television depends on the availability of or access to it at home or in the neighborhood. Large majority (77.8 percent) of adolescents aged 13-19 years watched television. Proportion of adolescents who watched TV is quite high in rural and urban areas alike. About 94 percent of adolescents in urban areas and 74 percent in rural areas watched TV (Figure 4.4).

Differentials in exposure to television by sex, marital status, education, working status and school enrollment can be seen in Table 4.1. Among the adolescents, significantly higher proportion of males than females (87.2 percent males vs. 68.8 percent females) watched TV. Unmarried, educated, currently working and currently enrolled adolescents are more likely to watch television than their counterparts.

Figure 4.4 Percentage of respondents watch TV , according to residence

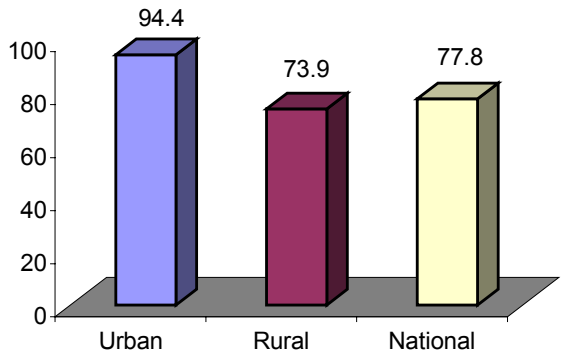
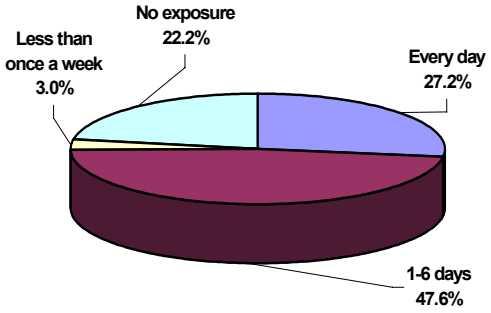


Figure 4.4a shows the percentage of adolescents viewing television by frequency of viewing. It shows that nearly one-third (27.2 percent) of the respondents watched television everyday and nearly half (47.6 percent) watched television 1 to 6 days in a week. Every day viewers were two and half times higher in urban areas (53.0 percent) compared to rural (21.1 percent) areas. In addition, more urban female adolescents watched TV every day compared to male adolescents (Table C4.2 in Appendix).

Figure 4.4a Percentage distribution of respondents by frequency of watching TV

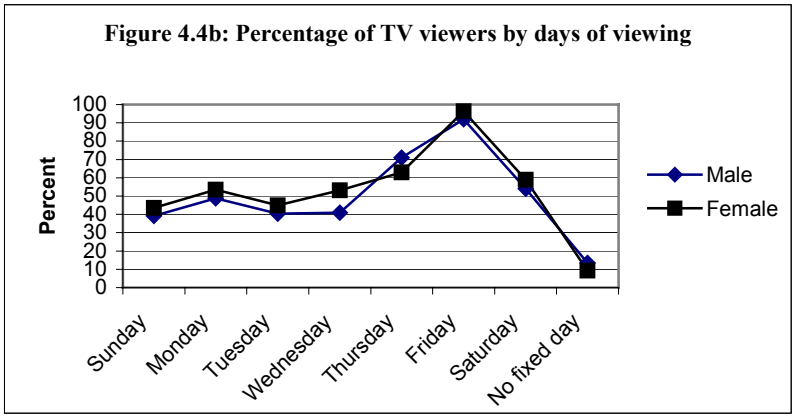


Overall, 36 percent of the adolescent viewers watched television at home, and 58 percent watched at relatives' or neighbors' houses. Significantly, a higher proportion of adolescent urban viewers (68.5 percent) had the opportunity to watch television at home compared to rural (26 percent) viewers and this was true for all the adolescents irrespective of their sex (Table C4.2 in Appendix).

Friday (94 percent) and Thursday (67.4 percent) were the most preferred days for watching television. Around fifty percent of the viewers also watched television on other days of the week. Only 11.5 percent reported that they had no fixed day for viewing. There is no marked variation in viewing pattern by days among urban and rural viewers.

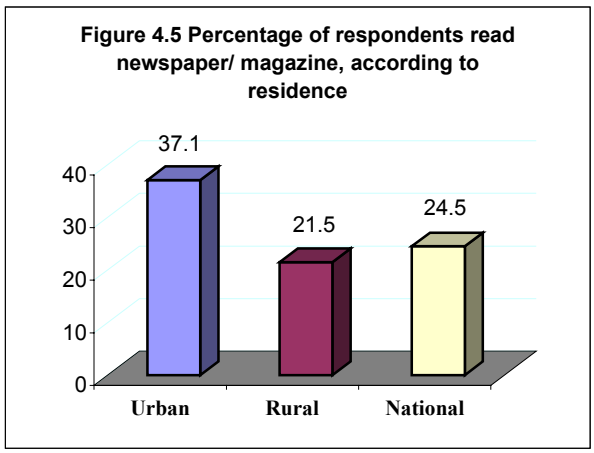
Only about 1 percent of the adolescents reported that they ever watched videos (Table 4.1).

Figure 4.4b: Percentage of TV viewers by days of viewing



4.4 Exposure to newspapers/magazines and other print media

Newspapers/magazines constitute a prime source of knowledge and information. Much information of diverge nature are available in them. Like other groups of the population, adolescents are expected to receive selected RH messages from this media when exposed to them. The survey results indicate that 24.5 percent of the adolescents interviewed had exposure to newspapers/ magazines and readership is substantially higher among urban adolescents (37.1 percent) than rural ones (21.5 percent) (Figure 4.5). Table 4.1 shows male adolescents (32.4 percent) are more likely than female adolescents (16.9 percent) to read newspapers/magazines. Readership also substantially higher among unmarried adolescents (27.8 percent) than married ones (5.9 percent). Readership of newspapers/magazines obviously depends on the level of education. At least some education is needed before one can read newspapers or magazines. Survey results confirm that readership increased with increase in the level of education; readership is higher among those adolescents who have a higher level of education.



Only 4.3 percent of the respondents read booklets containing information related to health. Although readership of such booklets is very low among adolescents, it is relatively higher among those having secondary level of education (7.0 percent) and currently enrolled ones (6.5 percent) (Table 4.1).

4.5 Exposure to selected RH messages from media

Certain reproductive health related messages are currently being made available through media. Those who have had exposure to the media are expected to be exposed to such reproductive health messages. This strategy is designed to generate awareness and improve knowledge of RH. Adolescents were asked whether in the last six months they had heard/seen/read reproductive health messages such as: *physical changes during puberty, menstruation, wet dreams*, *how pregnancy occurs, sexual harassment, postponing early marriage, postponing early pregnancy, ANC, PNC, contraception/family planning methods, tetanus toxoid, where to get reproductive health services, how to prevent HIV/AIDS, and how to prevent other sexually transmitted diseases* from radio, television, videos, newspapers or booklets. Table 4.3 gives percentages of adolescents by exposure to these RH messages through different media.

Table 4.3 Exposure to selected RH messages from media

Percentage of adolescent by exposure to selected reproductive health messages through different media

RH messages	Through media							
	Any Media		Radio		TV		Booklet	
	Male	Female	Male	Female	Male	Female	Male	Female
Physical changes during puberty	13.9	17.9	6.9	8.9	5.6	8.1	1.6	2.2
Menstruation	12.3	17.1	6.4	9.0	4.2	6.3	1.5	2.1
Wet dream	8.7	5.2	5.2	2.6	1.8	1.1	1.5	1.1
Sexual harassment	40.5	38.5	15.8	10.1	29.9	30.9	1.2	1.5
Postponing early marriage	58.5	55.4	34.1	28.7	46.5	42.3	2.0	2.6
How pregnancy occurs	27.3	24.3	14.7	10.3	19.0	17.1	1.9	2.2
Postponing early pregnancy	42.5	48.8	23.3	23.7	34.1	36.7	2.4	2.3
ANC/PNC	60.8	56.9	31.8	24.4	51.9	46.2	2.0	2.8
Contraception/FP	59.1	58.6	32.6	27.3	48.5	47.3	2.3	2.4
Tetanus toxoid	37.2	55.4	19.4	25.0	30.4	44.6	1.3	2.0
How to prevent HIV/AIDS	78.3	63.5	42.3	28.1	72.2	57.1	2.9	2.6
Where to get RH services	54.5	36.5	28.7	15.7	49.3	30.5	2.2	1.5
N	1811	1873	1811	1873	1811	1873	1811	1873

Adolescents do not have clear understanding about certain reproductive health matters such as the changes that take place in them associated with puberty. Among the male respondents 13.9 percent had heard about physical changes during puberty through any media. The corresponding proportion among the female respondents was 17.9 percent. Among the male and female respondents about 6.9 percent of male and 8.9 percent of female heard about it through radio, 5.6 percent of males and 8.1 percent of females viewed about it on TV and 1.6 percent of males and 2.2 percent of females read in books/ booklets respectively.

About 12.3 percent of male and 17.1 percent of female respondents heard about menstruation and 8.7 percent of male and 5.2 percent of female respondents heard about wet dream through any media. Radio seems to be a better source than TV and booklets for these messages.

In recent times different types of media are increasingly reporting incidences of sexual harassment and repression. About 40.5 percent of male 38.5 percent of female respondents had heard about such things.

Early marriage is discouraged for many reasons. It is expected that young people should have proper awareness about the disadvantages of early marriage. Media interventions can be very effective in generating awareness about this practice. The survey results show that among the male and female respondents almost equal proportion (58.5 percent of males and 55.4 percent of females) had learned about, and understood the importance of postponing early marriage from

media. Radio and TV seem to be equally important sources of this message. Exposure to messages like *how pregnancy* occurs and *how to postponed early pregnancy* through media can be seen also in table 4.3. About half of the male and female adolescents heard messages how to postpond early pregnancy through any media. However, only one-fourth heard messages how pregnancy occurs.

About *antenatal and postnatal care* (ANC/PNC) and *contraception/family planning methods*, the majority of the male and female respondents reported hearing about these through media. Among the respondents higher proportion got these messages through TV than other media.

About 78.3 percent among male and 63.5 percent among female adolescents (respondents) reported that they had heard about *how to prevent HIV/AIDS* from media. TV seems to be the number one source followed by radio. More males than females (54.5 percent of male and 36.5 percent of female respondents) had heard about *where to go to get RH services*. Again TV and then radio were the main sources of information.

Chapter 5

ATTITUDE AND PRACTICES REGARDING MARRIAGE, FERTILITY, AND FAMILY PLANNING AND ANC USE

Adolescence is a difficult period for most young people in Bangladesh, especially females. Majority female adolescents go through the pressure of marriage and pregnancy during this period. The present chapter is devoted to examining issues related to marriages, childbearing, family planning and ANC use. The discussion will mainly focus on issues relating to perceptions of adolescents about the ideal age of marriage and the ideal age at the onset of childbearing. This chapter also attempts to shed light on the adolescent's fertility preference and perceptions about ideal birth spacing as well as family planning behavior and ANC use.

5.1 Views about age at marriage

Among the demographic indicators, marital status is the most important one that influences female adolescents' lives. Despite a gradual upward trend in age at first marriage, females still get married at an extremely young age in Bangladesh. Most marriages take place below the minimum legal age of marriage, which is 18 years. Girls are considered eligible for marriage as soon as they show signs of pubescent growth. The search for a husband starts around the onset of menstruation for many girls and may even result in marriage for some of them before menarche (Amin, 1996).

Table 5.1 Views about ideal age of marriage
Percentage of all adolescents and married adolescents by sex, according to their views about the ideal age of marriage

Views about ideal age of marriage	Among all adolescents		Among married adolescents	
	Male	Female	Male	Female
Ideal age of marriage for a female				
Less than 18 years	8.3	9.5	10.8	12.9
18-19	50.2	50.1	29.7	50.5
20+	41.5	40.4	59.5	36.6
Mean	19.2	19.1	19.2	18.7
Ideal age of marriage for a male				
Less than 21 years	11.9	18.5	10.8	17.4
21-24	27.5	27.7	13.5	21.2
25+	60.7	53.8	75.7	61.4
Mean	24.5	24.3	25.4	24.8
N	18`2	1872	37	519

The survey gathered information from adolescents on their views about the appropriate age of marriages for both males and females. The results indicate that for most adolescents the stated ideal age at marriage for females is in line with the legal age for marriage (18 years) in Bangladesh. The reported mean ideal age at marriage was about 19 years, as reported by males and females (Table 5.1). In some recent studies, female adolescents have stated that the ideal age for marriage should be between 18 to 20 years (Nahar et. al 1999, Haider et. al 1997, Islam et. al 1995).

The stated ideal age at marriage for males, however, is well above the legal age of marriage for them (21 years) in Bangladesh. Adolescents have reported that the appropriate age for marriage for males is about 24 years.

Adolescents' views about the proper age for marriage appear to diverge from those of the actual age at marriage prevalent in society. Table 5.2 shows that despite adolescent's knowledge of the ideal age for marriage at a later age, most marriages of female adolescents took place at a very young age. The mean age of first marriage of female adolescents as reported in the present study is 14.6 years. The comparable figure, as recorded in the 1989 BFS, was 14.5 years. This does not indicate that there has been a rise in the age of marriage among adolescents over the last decade.

An attempt was made to know the views of respondents of their own age of marriage by asking them how they themselves felt about the age at which they were married. Was it appropriate for them in their own judgment? It is interesting to note that most of the adolescents' views were in conformity with their stated ideal. About 91 percent of the male, and about 87 percent of the female respondents who were married considered their age at marriage as too low and thus felt it to be inappropriate (Table 5.2).

Table 5.2 Percentage of married adolescents by views about their own age at marriages and reasons for early marriage

	Male	Female
Mean age at marriage	17.4	14.6
Views about their age at marriage		
Early age	91.1	86.9
Correct age	9.0	12.3
Late marriage	0.0	0.8
N	37	519
Reason for early marriage		
Forced by parents	75.6	85.9
Own preference	19.1	7.1
Other (financial, tradition, got pregnant) reasons	5.3	7.0
N	34	449

There were several reasons for mismatch between knowledge and practice regarding marriage mentioned by both male and female adolescents. Most of the adolescents surveyed, particularly the females, (75.6 percent for males and 85.9 percent for females) reported that they got married at an early age because they were forced to do so by their parents. Only about 7 percent of the female adolescents said that they got married early due to their own preference. In one recent study, the reasons for early marriages of girls stated by adolescents included: finding an eligible bridegroom, preventing premarital relationships and sex, avoiding anxiety by parents, and maintaining social norms (Nahar et. al, 1999). Some studies have also observed that many girls were not usually consulted about their marriage prior to the commencement of the event, and that they lack courage to disobey their parents' decision (Nahar et. al, 1999, Islam et. al, 1995). Male adolescents, however, reported enjoying somewhat greater freedom in deciding about the age of their marriage. About 19 percent of male adolescents got married at an early age because they wanted to.

5.2 Views about ideal age for having the first child

The age at which childbearing begins has important demographic consequences for the health and welfare of the mother and the child as well as for the society as a whole. Pregnancy during adolescence poses an increased risk of maternal and infant morbidity and mortality, resulting in an increase in cumulative fertility, and restricting the educational and economic opportunities available to women. Teenage mothers have a higher incidence of low birth weight, a condition associated with birth injuries, serious childhood illness, and mental and physical disabilities.

The survey gathered information on the ideal age for having the first child for girls and the ideal age for fatherhood for the male ones. Table 5.3a shows that the mean appropriate age for having the first child for females varied from 21.4 years (as reported by rural males) to 22.3 years (as reported by urban females). No significant variations can be observed in the reported ideal age for having the first child by rural-urban and male-female classification.

Table 5.3a: Views about ideal age for having the first child

Percentage of adolescents according to views about the ideal age for having the first child, according to sex and residence

Ideal age for having the first child	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
For a female						
Less than 20	16.2	14.1	7.2	7.6	14.6	12.7
20-24	71.7	70.8	74.3	72.4	72.1	71.2
25 +	12.1	15.1	18.5	20.0	13.3	16.1
Mean	21.4	21.6	22.1	22.3	21.5	21.7
For a male						
Less than 25	29.0	32.7	25.1	26.1	28.3	31.3
25-29	48.7	39.5	54.5	46.5	49.8	40.9
30+	22.3	27.9	20.4	27.4	21.9	27.8
Mean	26.7	26.8	26.9	27.2	26.8	26.9
N	1479	1492	332	380	1812	1872

The appropriate age for a male to become a father as reported by both male and female adolescents is quite high. About 72 percent of male adolescents and 68 percent of females viewed 25 years or more as the appropriate age for a male to become a father. The mean appropriate age for fatherhood is about 27 years and is approximately the same in rural/urban and male female classifications. The views of married female adolescents on ideal age for having the first child for females and males do not differ from the views of all adolescents (table 5.3b).

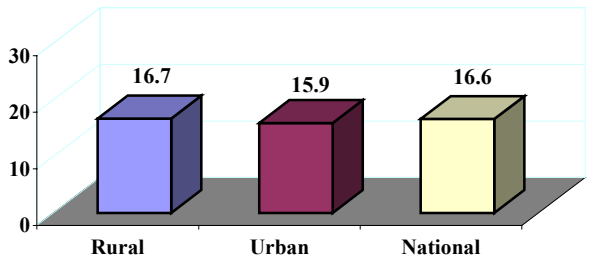
Table 5.3b: Percentage of married female adolescents according to views about the ideal age for having the first child

Ideal age for having the first child	Rural	Urban	National
For a female			
Less than 20	16.2	9.5	15.2
20-24	72.1	73.0	72.3
25 +	11.7	17.6	12.5
Mean	21.3	21.8	21.4
For a male			
Less than 25	25.7	21.6	25.1
25-29	43.2	50.0	44.2
30+	31.1	28.4	30.7
Mean	27.3	27.5	27.3
N	74	445	519

5.3 Pregnancy during adolescence

Information on pregnancy status is important because it is a 'current status' indicator of fertility behavior. Change over time in the percentage of pregnant females is an independent indicator of changes in fertility. Reports on current pregnancy are usually underestimates, since although many adolescents may have been pregnant they were not yet aware of their status. Information was collected about ever pregnancy in adolescence. All the female adolescents of the households listed in the survey for preparing sampling frames (female respondents and non-respondents) were covered. Table 5.4 shows that among all female adolescents 17 percent reported that they had pregnancies during adolescence (age 13-19) or were pregnant at the time of the survey. In Bangladesh, the proportion of pregnant females has generally declined over time, although not in a steady fashion. In the 1991, about 19.6 percent of currently married adolescents aged between 15-19 reported themselves pregnant at the time of the CPS survey. The figure steadily declined

Figure 5.1 Percentage of currently married female adolescent pregnant at the time of survey



to 14.7 in 1996-97 (BDHS 1996-97) but increased to 15.9 percent in 1999-00 (BDHS 1999-00). The results from this survey show that the proportion of currently pregnant females among currently married adolescents age 13-19 is 16.6 percent (Figure 5.1). There exist slight variations in the proportion of currently pregnant females. In rural areas this proportion is slightly higher (16.7 percent) compared to that in urban areas (15.9 percent).

Table 5.4 Teenage pregnancy
Percentage of female adolescents aged 13-19 who were ever pregnant by selected background characteristics

Background characteristics	Percentage who were ever pregnant[1]	Number
Age		
13	-	984
14	2.2	967
15	5.1	920
16	13.4	963
17	24.2	972
18	36.8	1297
19	47.5	749
Residence		
Urban	13.9	2724
Rural	19.4	3828
Total	17.0	6552

5.4 Views about ideal family size and ideal birth spacing

Ideal family size

Information on what women and men consider the ideal family size has gained importance in recent fertility research. The desire for more children tends to reflect the process of changing family size norms vis-à-vis future fertility desire. Adolescents constitute a distinct group who are physiologically, psychologically, and emotionally different than other age groups. The importance of this issue in framing population policy in relation to adolescent mothers should thus be obvious.

The survey gathered information on the ideal number of children by asking adolescents how many children they would have in their whole life. The data on Table 5.5 shows that the vast majority of the respondents could give a numeric answer to this question. Only 1.1 percent of male adolescents and 1.4 percent of females gave nonnumeric answers such as "God knows", "Don't know" etc. It is interesting to note that the majority of adolescents want to keep their family small. About 74 percent of female adolescents preferred a two-child family while another 13 percent considered a three-child family ideal. The mean number of ideal children is about 2.3

[1] Percentages were calculated multiplying the proportion of pregnant among currently married female adolescents in the sample by proportion of married female adolescents in the households listed for the preparation of the sampling frame

among female adolescents. This finding is comparable with that observed in BDHS 1999-00. This result indicates that perception of a two-child norm has become widespread in Bangladesh.

Table 5.5: Views about ideal number of children and birth interval
Percentage of adolescents according to views about ideal number of children and ideal interval between births, according to sex and residence

Views	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
Ideal number of children						
Less than equal to 2	63.8	70.8	82.9	84.5	67.3	73.6
3	19.0	13.9	12.1	10.4	17.7	13.2
4	10.1	10.6	4.1	4.6	9.0	9.4
5+	5.8	2.7	0.6	0.2	4.9	2.2
DK/God knows	1.3	2.0	0.3	0.2	1.1	1.7
Mean	2.54	2.37	2.16	2.10	2.47	2.31
Ideal birth spacing						
1 years	13.2	4.3	5.2	1.9	11.7	3.8
2	35.3	15.9	26.6	13.1	33.7	15.3
3	23.5	22.9	26.5	25.3	24.1	23.4
4+ years	28.0	56.9	41.7	59.6	30.5	57.4
Mean	2.89	3.94	3.46	4.13	3.00	3.98
N	1479	1492	332	380	1812	1872

Among male adolescents, the preferred number of children is somewhat higher than their female counterparts. Among male adolescents, about 67 percent preferred a two-child family and another 18 percent said that they would go for a three-child family. The mean number of ideal children preferred by male adolescents is about 2.5. Not much variation is observed according to rural-urban classification.

Birth intervals

Information on birth intervals provides insight into birth spacing patterns. Such information has a far-reaching impact both on fertility and child mortality levels. Children born too soon after a previous birth are at increased risk of dying at an early age.

Reasons for girls having early pregnancies stated by adolescent couples include: girls have to prove their fertility, having a child make the marital bond strong, and lack of knowledge about fertility and family planning methods (Nahar et. al, 1999).

The survey gathered information on views about ideal spacing between two births by asking respondents how long one should wait to have another child. The result presented in Table 5.5 indicate that reported ideal birth spacing is generally long in Bangladesh. More than 57 percent of female adolescents questioned report that 4 years or more is ideal spacing between births

while another 23 percent report 3 years as ideal for birth spacing. Only about 19 percent of female adolescents mentioned a 'too short' interval (less than 24 months) as ideal space between births.

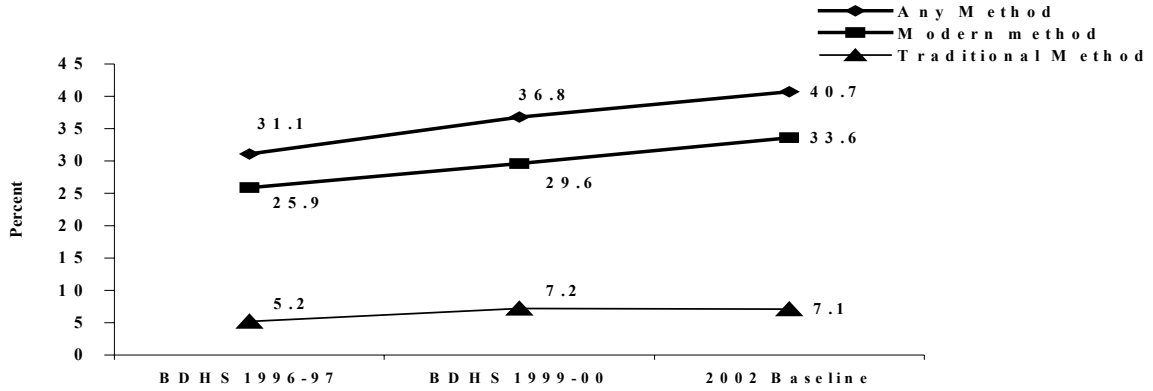
Male adolescents, however, preferred to have the next birth within a comparatively shorter interval. More than 45 percent of male adolescents mentioned 'too short' interval (less than 24 months) (compared to 19 percent for female) while only 30 percent considered 4 years or more as ideal spacing between births.

Significant differences in perception about ideal birth spacing exist among rural-urban adolescents. Mean ideal birth spacing reported by females range from 3.9 years in rural areas to 4.1 years in urban areas, while among females, it ranges from 2.9 years to 3.5 years.

5.5 Current use of contraception

Studies in both developed and developing countries demonstrate that the behavioral patterns of contraceptive acceptance and use differ significantly between adolescents and adults (United Nations, 1989). This difference may be attributed to the maturity, higher knowledge and access to services and experiences among adults compared to among adolescents. Although individual characteristics such as desired family size, birth spacing, and contraceptive use are significant, there are some social policies and factors that affect the use of contraceptives by teenagers, which are different from those affecting adults.

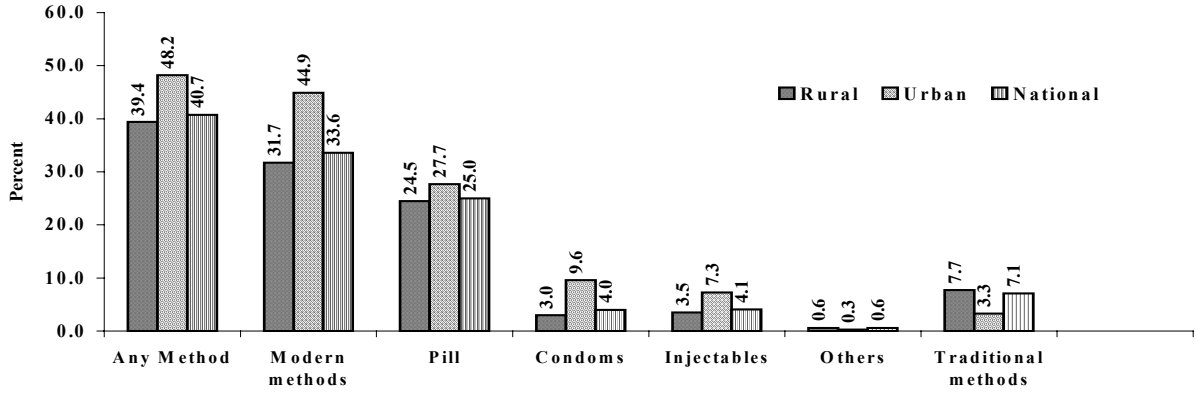
Figure 5.2: Trend in contraceptive use among currently married females aged 13-19, 1996-2002



In the survey, married adolescents were asked about use of family planning methods and where they got access to them. Since the number of married males was small, use pattern for only currently married female adolescents is presented. Current use of contraception among currently married female adolescents of age 13-19 has been increasing steadily from about 31 percent in 1996-97 to about 41 percent in 2002 (Figure 5.2). Modern methods are preferred (33.6 percent) among married female adolescents over traditional methods (7.1 percent). Nevertheless, traditional methods still constitute major means of contraception among adolescents in Bangladesh.

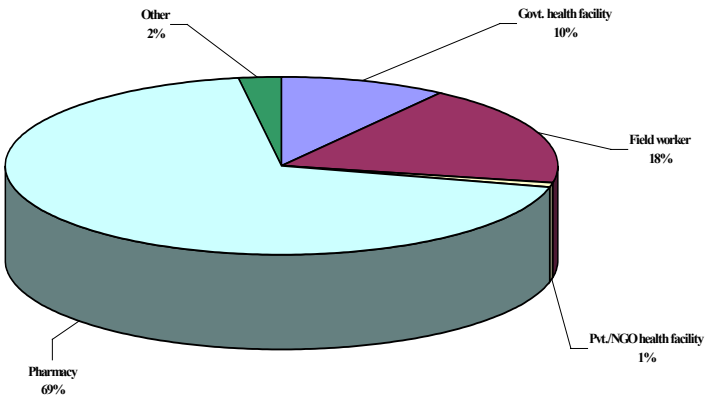
The pill continues to be by far the most popular method of contraception among adolescents. It is used by 25 percents of currently married females (Figure 5.3). Injectables and condoms are the next popular methods and are used by 4.1 percent and 4 percent of them respectively.

Figure 5.3: Contraceptive prevalence rates among currently married females



Current use of contraceptives varies considerably according to residence. Contraceptive use is higher among currently married females in urban areas (44.9 percent) than in rural ones (31.7 percent).

Figure 5.4 Distribution of current user of pill by source of



Pill accounts for 74 percent of current users of modern methods. Pharmacies continue to be the main source of contraceptive supply (Figure 5.4). About 69 percent of the pill users got their supply from pharmacies. Field worker, particularly in rural areas, is still a very important source of contraceptive supply (18% percent). Govt. health facilities (10 percent), and private health facilities (1 percent). These findings are consistent with Nahar et. al's (1999) findings about sources of contraceptive supply.

Reasons for non use of FP methods

Table 5.6 presents data on main reasons for why some married adolescents do not use available family planning methods. Desire for child appears to be the primary reason for non-use of contraception among currently married female non-users. About 62 percent (28.2 percent wanted a child and 33.6 percent were pregnant) currently married female adolescents were not using family planning methods, because they were either pregnant at the time of the survey or wanted a child in the near future. Lactational amenorrhoea/breastfeeding was the next most commonly cited reason for non-use (17.4 percent). Other reasons mentioned include infrequent sex (7.5 percent), side effects /health concerns (7.5 percent) and opposition from husband/ relatives (5.3 percent).

Table 5.6: Reasons for non-use of contraception
Percentage of currently married female adolescents not using any method according to major reason for non-use

Reasons of non-use	Percentage
Currently pregnant	28.2
Wants child	33.6
Lactational amenorrhoea/Breast feeding	17.4
Health concerns/side effects	7.5
Opposition from spouse/relatives	5.3
Infrequent sex, husband away	7.7
Others (fatalistic, don't know source, cost etc)	6.9
N	297

5.6 Use of antenatal care

It is believed that the risk of prenatal mortality is high among babies of young mothers. A well-designed and implemented antenatal program helps in detecting problems and treating complications during pregnancies among young mothers. Because the information collected was not adequate, the results in the following table is based on BDHS 1999-00 data obtained from adolescent mothers (age 13-19 years) on last live births in the five year preceding the survey.

The prevalence of antenatal care coverage is still low among adolescents. Almost two-thirds of the adolescent mothers questioned did not have antenatal visits. This findings can be compared with BDHS (1999-00) data reporting only 35 percent of women received antenatal services from a medically trained provider (i.e. Doctor/ nurse/ midwife).

Timing and number of antenatal care visits are important in preventing complications during pregnancy. Care is most effective if mothers have their antenatal checkups early during pregnancy and continue to do so at regular intervals. The results, however, show a discouraging picture of antenatal care utilization by adolescents. Among those who did obtain care only about half of them (22.7 percent) received antenatal care before the sixth months of gestation while

only 14.2 percent had 3 or more antenatal visits (considered the minimum required for effective antenatal care).

Tetanus Toxoid coverage among adolescents, however, is widespread in Bangladesh. About 72 percent of adolescents had two or more doses of TT, which is considered sufficient for full protection against neonatal tetanus among newborns.

Table 5.7 Antenatal care

Percent distribution of last births in the five years preceding the survey among married female adolescents currently aged 13-19 according to sources of antenatal care, number and timing of antenatal visits and TT vaccinations, BDHS 1999-00

Characteristics	Percent
Antenatal care provider	
Doctor	22.5
Nurse/midwife	12.6
Birth attendant (trained and untrained)	0.7
Others	3.9
No visit	60.3
Number of antenatal visits	
0	60.3
1	13.9
2	11.2
3+	14.2
DK/missing	0.4
Number of months pregnant at the time of first visit	
<6 months	22.7
6-7 months	10.4
8+ months	6.6
No visit	60.3
Number of TT injections	
None	13.9
One dose	14.4
2+ dose	71.6
DK/Missing	0.1
N	954

Chapter 6

KNOWLEDGE ABOUT STI HIV/AIDS AND OTHER REPRODUCTIVE HEALTH ISSUES

Knowledge of reproductive health problems among adolescents is inadequate. Adolescent-friendly health care facilities are not easily available in the country. Moreover, adolescents tend to avoid consulting proper health care providers for reproductive health problems. The adolescent group is likely to face a wide variety of reproductive health problems such as unwanted pregnancy, STIs including HIV due to lack of accurate information. Although the survey did not collect information on RH knowledge, attitude and behaviour as a whole, it collected some selected information that include knowledge about HIV/AIDS and other STIs, whether adolescent discuss RH issues with others, know different uses of condoms and their preferred source of RH information.

6.1 Knowledge about HIV/AIDS

AIDS- Acquired Immune Deficiency Syndrome- was recognized as a global problem by the mid-1980s. HIV/AIDS is now the fourth largest cause of death globally and the leading cause of death in Africa (WHO 1999). Although HIV/AIDS prevalence in Bangladesh is not alarmingly high, according to sero-surveillance survey high-risk behaviour is well established. Given the situation, various government and non-government organizations and agencies have taken up communication programs through the media to generate mass awareness about its risk and how to prevent HIV transmission.

Considering the importance of HIV/AIDS knowledge, questions were asked to assess adolescents' knowledge and perceptions relating to HIV/AIDS. The table 6.1 shows that most adolescents (in fact, more than 95 percent) whether male or female, of urban areas had heard about HIV/AIDS. The rural adolescents, particularly females, had a substantially lower level of knowledge about HIV/AIDS compared to that of the urban adolescents. Knowledge of HIV/AIDS seems to be higher among both male and female adolescents compared to their older counterparts. BDHS 1999-00 shows that about 31 percent of females of age 15-49 years and 50 percent of males age 15-59 years heard of AIDS.

When asked about the route of transmission of HIV/AIDS, about 85 percent of male respondents and 74 percent female ones who had heard about HIV/AIDS provided at least two correct answers Table 6.1). The most common route of transmission of HIV/AIDS cited by male adolescents, irrespective of their residence, is the *use of non-sterile needle/syringe (65.2)* followed by *through blood transfusion (50.8)*. *Sex with commercial sex worker* (47.8 percent), not *using condom during intercourse* (42.4 percent) and *sex with multiple sex partners* (42.0 percent) are other main modes of transmission of HIV/AIDS, according to the male adolescents. According to the female adolescents, the most frequently reported modes of transmission of HIV/AIDS are *multiple sex partners* (63.3 percent), *u*se *of non-sterile needle/syringe* (53.8 percent), *through blood transfusion* (39.7 percent) and *sexual intercourse with an infected person*

(29.2 percent). It is interesting to note that only a few adolescents gave incorrect answers about the mode of transmission of AIDS.

Table 6.1 Knowledge about HIV/AIDS
Percentage of adolescents by knowledge about HIV/AIDS, according to sex and residence

Knowledge	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
Heard about HIV/AIDS	80.1	67.4	97.3	95.3	83.2	73.1
N	1479	1492	332	380	1810	1874
Know mode of transmission of AIDS						
Sexual intercourse with an infected	30.9	31.9	26.4	21.8	29.9	29.2
Sex with commercial sex worker	48.3	11.6	45.7	12.8	47.8	11.9
Sex with multiple sex partner	44.4	62.9	33.3	60.5	42.0	62.3
Not using condom during intercourse	41.3	27.4	46.3	21.5	42.4	25.8
Through blood transfusion	48.0	36.9	60.8	47.6	50.8	39.7
Use of non-sterile needle/ syringe	62.6	51.2	74.5	60.9	65.2	53.8
Baby from an HIV infected mother	18.5	19.0	17.1	21.7	18.2	19.8
Know at least two mode of transmission of AIDS	83.9	72.7	86.6	77.1	84.5	73.9
Know ways to prevent transmission of AIDS						
Abstain from sex	11.6	7.8	12.5	7.4	11.8	7.2
No sex with HIV infected partner	29.3	30.8	19.8	20.7	27.2	28.7
Use condom during sexual intercourse	63.6	42.5	59.8	44.4	62.8	43.0
Limit sex within marriage	18.6	29.0	21.3	27.0	19.2	28.4
Limit sex within trusted partner	3.8	4.2	0.4	10.0	3.1	5.7
Avoid sex with commercial sex worker	33.6	8.0	32.8	6.4	33.4	7.6
Avoid multiple-sex partners	5.7	6.6	6.7	3.2	5.9	5.7
No indiscriminate sex	5.2	13.5	2.0	5.7	4.5	11.5
Avoid unsafe blood transfusions	49.9	34.5	63.0	48.6	52.7	38.2
Avoid unsterilized needles/ syringe	60.5	48.7	74.2	60.5	63.4	51.8
Know at least two ways to prevent transmission of AIDS	85.1	68.6	86.7	74.9	85.5	70.3
Heard/know at least two modes of transmission and two ways to avoid HIV/AIDS	65.8	44.4	83.7	68.7	69.1	49.3
N	1184	1006	323	362	1507	1368

Knowledge about ways to avoid contracting HIV/AIDS seems to be quite high. About 86 percent of male and 70 percent of female adolescents, who had heard about HIV/AIDS, were able to provide at least two correct ways to prevent HIV/AIDS. According to male adolescents, the most frequently mentioned ways to avoid HIV/AIDS are: use *sterilized needles/syringe* (63.4 percent), *use condom during sexual intercourse* (62.8 percent), *avoid not-tested blood*

transfusion (52.7 percent), *avoid sex with commercial sex workers* (33.4 percent) and *no sex with HIV infected partner* (27.2 percent). According to female adolescents, use *sterile needle/syringe* (51.8 percent), *use of condom during sexual intercourse* (43.0 percent), *avoid not-tested blood transfusion* (38.2 percent), *no sex with HIV infected partners* (28.7 percent), and *limiting sex within marriage* (28.4 percent*) are the main ways to avoid having HIV/AIDS.*

Although awareness about AIDS/HIV is quite high among adolescents, in terms of completeness and adequacy it does not seem to be that high. The survey data shows that less than half of the female adolescents reported that they heard about AIDS, know at least two modes of transmission, and also know at least two ways of avoiding AIDS (Figure 6.1a). Substantial rural urban differences have also been observed (Figure 6.1b).

Adolescents were also asked about specific views regarding AIDS: *Can a healthy person have AIDS? Chance of getting AIDS more for multiple sex partners? Is AIDS curable?* Results presented in table 6.2 examine the responses to the above questions by background characteristics of respondents. Of those who had heard of HIV/AIDS, 68.1 percent of male respondent, and 63.3 percent of the females perceived that even a healthy person could have AIDS. BDHS 1999-00 reported similar prevalence of this knowledge among older males and females. A higher proportion of rural adolescents (68.5 percent) compared to their urban counterparts (59.2 percent) were of the above opinion. Education seems to have had a positive effect in their statement of the above proposition, but marital status and working status of the adolescents did not make any difference in their stance on this issue.

Figure 6.1a: Knowledge of HIV/AIDS by

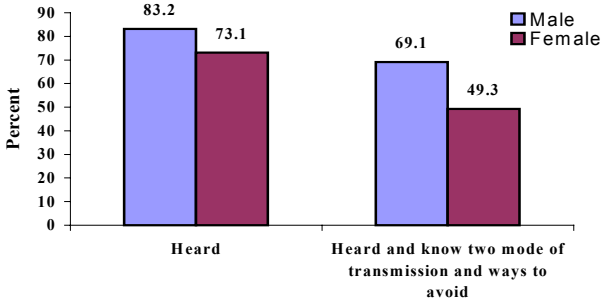
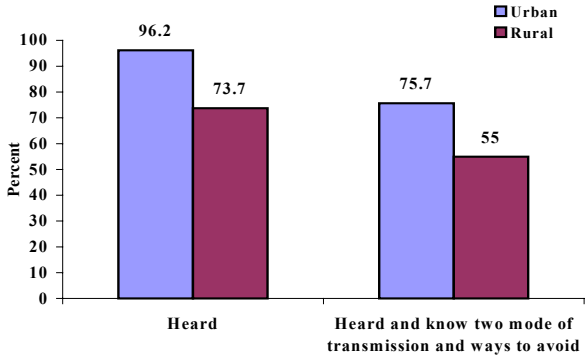


Figure 6.1b: Knowledge of HIV/AIDS by residence



Half of the male respondents and about 31 percent of the females said that the chance of getting AIDS is more if one had multiple sex partners. About one-quarter believe that AIDS is curable. There seems to be not much variation in perception according to other selected background characteristics such as residence, marital status, education and working status.

Table 6.2: Percentage of adolescents who have heard of AIDS by perception of AIDS, according to selected background characteristics

Background characteristics	Can a healthy person have AIDS?			Chance of getting AIDS more for multiple sex partners?			Is AIDS curable?			
	Yes	No	DK/ Missing	Yes	No	DK/ Missing	Yes	No	DK/ Missing	Number
Sex										
Male	68.1	25.0	6.1	50.4	3.4	46.2	20.8	75.2	4.0	1506
Female	63.3	29.5	7.2	30.8	2.6	66.7	24.7	65.5	9.8	1370
Residence										
Urban	59.2	33.8	7.0	42.6	3.9	53.4	24.2	67.7	8.0	686
Rural	68.5	25.0	6.5	40.5	2.7	56.8	22.2	71.5	6.3	2191
Marital Status										
Married	64.0	26.5	9.5	34.4	2.0	63.7	24.8	64.3	10.9	358
Unmarried	66.6	27.2	6.2	42.0	3.1	54.8	22.4	71.5	6.2	2518
Education										
No	56.7	30.5	12.8	40.2	5.5	54.3	25.0	62.8	12.2	164
Primary incomplete	60.7	28.7	10.7	41.4	4.3	54.3	25.2	62.7	12.1	373
Primary complete	73.2	19.7	7.0	52.5	6.7	40.8	21.3	69.7	8.9	314
Secondary +	67.0	27.7	5.3	39.2	2.0	58.8	22.3	72.7	5.0	2022
Working status										
Currently working	68.9	24.8	6.2	47.1	4.4	48.4	26.0	68.4	5.6	789
Not working	65.3	28.0	6.8	38.8	2.4	58.8	21.4	71.4	7.2	2085
All	66.2	27.1	6.6	41.0	3.0	56.0	22.7	70.6	6.8	2876

When questioned about the source of information about HIV/AIDS most adolescents (90 percent males and 85 percent females) mentioned TV as the prime source (table 6.3). Radio is the next important source of information about HIV/AIDS, particularly in rural areas, where respondents have mentioned that fifty percent of them have heard about the problem from radio. Print media, particularly among urban male adolescents, seems to be another prime source of information, next important to TV.

Table 6.3 Source of knowledge about HIV/AIDS

Percentage of adolescents who have heard of HIV/AIDS by source of knowledge, according to sex and residence

Source of information about HIV/AIDS	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
Radio	59.0	50.9	32.3	23.4	53.3	43.6
TV	89.4	81.7	94.5	96.5	90.5	85.6
Print media	32.4	17.0	60.0	35.9	38.3	22.0
Health personnel	4.3	5.0	4.6	4.2	4.3	4.8
Friend/relatives	25.4	20.0	31.4	20.4	26.7	20.2
N	1184	1006	323	362	1507	1368

6.2 Knowledge about Sexually Transmitted Infections (STIs)

Restrictive socio-cultural norms inhibit disclosure of information about sexual activities and other reproductive health related issues to unmarried adolescents (Population council, 1997). Few adolescents are aware of accurate information, especially of more complicated symptoms of sexually transmitted diseases. As shown in Table 6.4, only 4.7 percent of rural boys and 3.6 percent of rural girls have heard of such diseases. Such knowledge is relatively higher among urban adolescents. Knowledge about types of sexually transmitted infections is even less among adolescents. Only about 2 percent of rural females could identify diseases such as gonorrhea, and syphilis as STIs. Not surprisingly, the level of knowledge of STI among adolescents is comparatively low compared with that among older males and females as observed in BDHS 1999-00, where about 11 percent of women (age 10-49) and 19 percent of men (age 15-59) had heard of STIs.

Table 6.4 Knowledge about STIs

Percentage of adolescents heard about STI, percentage who heard of STI know of sign and symptoms associated with STIs in men and women, and know mode of transmission and ways to prevent STIs, according to sex and residence.

	Rural		Urban		National	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Heard about STI	4.7	3.6	7.5	5.3	5.2	4.0
Types STI heard						
Gonorrhea	4.1	1.9	6.6	3.4	4.6	2.2
Syphilis	3.5	2.1	5.1	3.9	3.8	2.5
Other STI	-	0.4	-	-	-	0.3
N	1479	1493	333	380	1812	1872
Knowledge of specific signs or symptoms of STIs in men and women						
Know at least one specific signs/ symptoms of STIs in men	85.1	47.2	46.7	11.3	75.0	37.5
Know at least one of specific signs / symptoms of STIs in Women	12.8	30.5	8.0	11.3	11.5	25.0
Knowledge about modes of transmission and ways to avoid STI						
Know at least two mode of transmission of STI	44.7	25.0	46.7	20.7	46.1	25.0
Know at least two ways to avoid STI	36.2	30.5	42.7	24.5	36.5	27.5
N	70	54	25	20	95	74

When asked about the sign and symptoms of such diseases, 75 percent of males and 37 percent of female adolescents who heard about STIs were able to mention at least one correct symptom of STIs in men. Awareness of correct symptoms of STIs among women is also very low; 11.5 percent of male and 25 percent of female adolescents who heard of STI were able to mention at least one symptom in women correctly.

Most adolescents who heard about STIs were able to say that these diseases are transmitted by sexual contact: s*ex with infected person, sex with sex worker and sex with multiple sex partners.* The majority of adolescents could not identify any of the preventive measures to be adopted to avoid STIs. Among male adolescents who had heard of STIs, the majority suggested *avoid sex with commercial sex workers* as a preventive measure of STIs. It is interesting to note that u*se of condom during sexual intercourse* is the most cited way among females and the second most cited way among males as a preventive measures against STIs (table C6.1 in Appendix).

Friends/relatives seem to be major sources of information about STIs. Print media such as book/booklets, magazines etc also seem to be sources of information about STI, followed by Radio and TV (Table C6.2 in Appendix).

6.3 Sources of RH information

Adolescence is a crucial period of life when certain physical and emotional changes occur in people. Signs of such changes include: weight gain, becoming taller, breast development, menstruation, hair growth in different parts of the body, etc for girls, and weight gain, becoming taller, appearance of beards and mustache, appearance of hair on the chest and other parts of the body, thickening of voice, wet dreams and development of genitalia for boys. Respondents were asked whether they ever discussed with others about the changes they experience during puberty particularly menstruation among females and wet dreams among male adolescents. Table 6.5 shows that more than two-fifths of male and more than two-thirds of female adolescents ever discussed these situation with others. For males friends and peers seem to be most preferred persons (95 percent) to discuss these changes irrespective of residence status. Females, however, discussed the issue with parents (43.2 percent), friends/peers (43.1 percent), other relatives (33.2 percent) and siblings (30.1 percent).

It is evident that friends/relatives and health personnel are the two most cited sources of information about these RH issues. For information about the physical changes that take place during puberty, *friends/relatives* as well as *health personnels* are preferred sources for about 60 percent of the males, whereas 82 percent of females prefer *friends/relatives,* 60 percent of males and 45 percent of females are in favor of consulting *health personnels* for the same information. For information about conception, about 71 percent of males and 60 percent of females prefer *health personnels* and 51 percent of males and 74 percent of females prefer *friends/relatives*. It is interesting to note that the media is not mentioned as preferred sources for RH information for most adolescents (Table 6.6).

Table 6.5 Discussion of RH issues

Percentage of adolescents discussed about selected RH matters and persons discussed with, according to sex and residence

RH matters	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
Discussed physical changes during puberty	38.9	63.9	55.3	87.1	41.9	68.6
N	1478	1494	332	380	1810	1874
Persons discussed with						
Parents	2.0	40.0	3.5	52.4	2.4	43.2
Siblings	2.4	28.7	3.7	34.0	2.7	30.1
Sister in law/ brother in laws	9.9	22.9	2.0	13.8	8.0	20.6
Grand parents	2.1	5.5	0.5	3.6	1.8	5.0
Other relatives	17.9	30.0	12.5	28.1	16.6	29.5
Friends/peers	94.8	41.0	97.1	49.2	95.4	43.1
Health personnel	3.2	2.2	2.5	0.8	3.0	1.8
Others	2.1	0.0	2.0	0.2	2.0	0.1
N	576	954	184	331	759	1285
Discussed conception (among married adolescents)	48.5	59.0	75.0	71.6	51.4	60.8
N	33	444	4	74	37	518
Persons discussed with						
Parents					-	11.4
Siblings					-	7.3
Sister in law/ brother in laws					89.5	73.0
Grand parents					-	5.4
Other relatives					-	54.3
Friends/peers					42.1	19.0
Health personnel					10.5	12.4
Others					-	1.3
N					19	315

Table 6.6: Percentage of adolescents according to preferred sources of selected RH information

RH matters	Rural		Urban		National	
	Male	Female	Male	Female	Male	Female
Physical changes during puberty						
Radio	10.6	7.8	5.5	5.8	9.7	7.4
TV/Video	11.1	6.9	12.5	12,4	11.5	8.0
Print media	6.5	6.5	14.5	9.7	8.0	7.2
Health personnel	58.5	40.5	67.7	60.9	60.2	44.6
Friends/relatives	60.7	83.3	59.1	76.8	60.4	82.0
Others	17.4	4.9	4.0	2.2	14.9	4.4
N	1478	1494	332	380	1810	1874

6.4 Knowledge about dual protective role of condom

The condom is the only contraceptive method that can protect against sexually transmitted diseases as well as pregnancy and thus is vital in controlling HIV/AIDS and STIs among the youth. Considering the importance of knowledge about the dual role of condoms, adolescents were asked whether they knew both the uses of condoms. The study shows that, irrespective of residence status, male adolescents are well aware of both benefits of using condoms (Table 6.7). Four-fifths of male adolescents heard about condoms compared to 71 percent among female adolescents.

Nearly two-thirds of male adolescents who knew about condom mentioned use of condoms both as a family planning method and for preventing HIV/AIDS. However, the knowledge is substantially lower among female adolescents in rural as well as urban areas. Only 36 percent of rural females and 45 percent of urban females reported that the condom as a preventive measure to avoid pregnancy and HIV/AIDS.

Table 6.7: Percentage of adolescents who have heard about condoms and have knowledge of the different uses of condoms

	Rural		Urban		National	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Heard about condom	78.2	67.5	91.3	83.4	80.6	70.7
N	1480	1492	332	380	1812	1872
Use of Condom, among those who know about condom						
As a contraceptive method	81.9	83.0	78.9	68.3	81.3	79.5
As a preventive measure of HIV/AIDS	73.1	48.5	81.2	64.0	61.3	38.1
As a preventive measure of STIs	5.0	3.2	5.0	4.4	5.0	3.5
Both (FP methods and preventive measure of STI or HIV/AIDS)	59.8	36.1	66.8	44.6	61.3	38.2
Others	2.8	1.7	3.1	2.7	2.9	1.9
DK	0.9	2.3	9.5	8.9	1.7	3.9
N	1158	1007	303	317	1461	1324

Knowledge about the use of condom as a preventive measure against other sexually transmitted infections (STIs) is very low. Only 3.5 percent of female and 5 percent of male adolescents have mentioned that a condom can be used as a preventative measure of STIs. This is not surprising since very few adolescents are aware of sexually transmitted infections other than HIV/AIDS.

Chapter 7

DISCUSSION AND RECOMMENDATIONS

Adolescents constitute an important socio-demographic group for policy makers in the health sector because of their sheer numbers and its significance in the reproductive health status of Bangladesh. This has triggered an increase in programs for adolescents over the last decade, both in the governmental and non-governmental sectors. These programs, however, targeted married female adolescents only. With the recent threat of HIV epidemic, the definition of reproductive health services and the target population have been broadened. Under the current Health and Population Sector Program (HPSP) of the Government of Bangladesh, both unmarried and married adolescents have been identified as underserved population and thus a priority target group for a variety of reproductive health services. Similar program initiatives have been taken by the non-government organizations and international agencies such as USAID, UNICEF and UNFPA.

As a part of these programs, the baseline survey was conducted to establish the benchmark status of adolescents in three major areas: first, the extent of contacts with major media outlets, second, knowledge about a range of reproductive health issues, and third, the extent of their access to reproductive health information and services. Following these three areas, a discussion of some major study findings and their implications in relation to present and future programs are made. The section concludes with a list of recommendations and a set of indicators for monitoring and evaluation.

Media Exposure

The rapid expansion of media in Bangladesh has created new channels for making information available to adolescents. Radio, television, newspapers, magazines, videos, and booklets are important ways of providing reproductive health information to adolescents. The study findings show that the coverage of any of the above-mentioned media among adolescents is quite high even though there are differences in coverage according to sex, residence, marital status, school enrollment, education and the working status of adolescents. Among different media, television is the most widely viewed medium by adolescents. About 94 percent of urban adolescents and 74 percent of rural adolescents watch television and about half of urban adolescents and one-fifth of rural adolescents watch television everyday. This is expected, given the fact that household ownership of television has increased from eight percent in 1995 to 14 percent in 1998 and 25 percent in 2002 (NMS 2002). This increase is more marked in rural areas compared to urban areas.

Radio is also an important medium for adolescents through which they can get reproductive health-related information. More specifically, radio seems to be an important medium and source of information for rural adolescents compared to urban adolescents. For instance, over half of the rural adolescents surveyed (56.4 percent) have listened to radio compared to less than one-third of the urban adolescents (29.9 percent). Radio listenership is more common among males than females and Friday is the most preferred day for listening to radio.

These findings indicate the preferred channels of communication that should be used to reach adolescents in Bangladesh with appropriate information. These channels could easily be used in order to access the gatekeepers especially those (parents, relatives, friends) adolescents rely most.

Knowledge, Attitudes and Behaviors about reproductive health issues

A *culture of silence* exists in Bangladesh – both at home and at the policy level -- that inhibits open discussion regarding reproductive health issues. Given this restrictive social and cultural context in Bangladesh, it is perhaps not surprising to find that adolescents' knowledge about reproductive health is poor. They have limited knowledge about the physical changes taking place in them during puberty includes menstruation and wet dreams. Though a high rate of discussion of reproductive health-related issues was observed among adolescents surveyed, the efficacy of these sources is questionable. In order to prepare adolescents in the fight against all negative aspects of reproductive health including HIV/AIDS, they should be provided with accurate information and clarification for any misperceptions. It was found that correct knowledge may get blurred with misperceptions and incorrect attitudes, and thus high level of knowledge may not be conducive to desirable behavior change.

Knowledge of, attitudes toward and behavior regarding other reproductive health issues such as conception, family planning, and STIs are discussed in the following section.

Marriage and Fertility

Adolescents seem to be aware of the ideal age for marriages, the ideal age for having the first child and other fertility-related issues.

Various social, cultural and situational reasons for arranging an early marriage by parents, as illustrated in Chapter Five, show that in most instances a daughter or son has very small role to play in deciding the timing of marriages with their parents. This finding could be compared with the result of ideal age of marriage stated by adolescents in this survey. A clear gap between ideal age and age of actual marriage exists among respondents. 91 percent of all married males and 87 percent of all married females described their marriages as "early". In this regard, the mean age of marriage should be noted, which are 17.4 for male adolescents and 14.6 for females.

Similarly, despite adolescents' knowledge about the ideal age of having the first child for females, which varied from 21.4 years to 22.3 years, survey data shows that the proportion of pregnant women among married females aged 13-19 is 16.6 percent. In spite of a successful family planning program among adult population, Bangladesh Government failed to reach married adolescents with modern family planning methods. The over emphasis on traditional methods until one child is born among married adolescents suggests that fear exists among adolescent population, which is: modern methods may impair one's fertility. A major group of adolescents in the study reported that they do not use contraceptive methods for the reason of either wanting a child or being pregnant or lactating.

These findings suggest that the social and cultural pressure on adolescents in terms of continuing the traditional practices such as early marriage and early pregnancy in order to prove women's fertility is enormous.

Sexually Transmitted Infections (STI) including HIV/AIDS

The study collected information on HIV/AIDS and other sexually transmitted infections and knowledge of dual protective role of condoms.

As reported in Chapter Six, adolescents surveyed for this study demonstrated high-level of knowledge about HIV/AIDS. Television and radio are the two main sources of information about HIV/AIDS. More than three-fourth of adolescents were able to provide at least two correct answers about modes of transmission as well as ways of preventing of HIV/AIDS.

Further details regarding knowledge of transmission of HIV demonstrates attitude-related aspects among this population. It shows that adolescents (about 50 percent) are more inclined to the idea that sexual intercourse with sex workers and multiple partners are responsible for transmission of HIV ignoring the fact that anyone with HIV infection can pass the germ. Consequently, this generates the idea of being invincible to HIV/AIDS among adolescent population, as they perceive them not at-risk to contracting HIV/AIDS. Similar findings are reported elsewhere in the world.

On the contrary, knowledge about STIs excluding HIV/AIDS is quite low. Only about five percent of males and four percent of females know of STIs. Knowledge about modes of transmission and ways of preventing STIs is even lower. On an average, only one-fourth of females and one-third of males, who heard of STIs, were able to mention two modes of transmission and two ways of preventing such diseases. This finding implies that the more complicated form of transmission of STIs is yet to be comprehended by adolescents.

Heath experts recognize condom as the most effective means of protection from STIs including HIV/AIDS. The study results show that 61 percent of males and 38 percent of females are aware of condom as both a family planning method and a way of preventing AIDS/HIV and STIs.

Health seeking behavior

Though not asked in the survey, utilization of reproductive health services is found poor among adolescents as noted in other studies. However, in the long run, when awareness of negative aspects of reproductive health will prevail cultural taboos, adolescents are expected to develop a sense of initiative in order to utilize the health services, including use of condom, if required. Although the Government of Bangladesh is committed to improving reproductive health services for adolescents, the current Health and Population Sector Program does not provide any clear guidelines on how to achieve this goal. For the government, this is bound to be a formidable task, given the fact that providing adolescent friendly health services implies reorganization of the existing reproductive health services and reorientation of health staff engaged in planning, organization and delivery of health services.

Suggested indicators to monitor the progress of BCC programs

The baseline survey was conducted to facilitate monitoring the effectiveness of BCC programs initiated under the leadership of BCCP. The current survey was aimed to establish the benchmark status of the extent to which adolescents have contacts with major media outlets, their knowledge about a range of reproductive health issues, their access to reproductive health

information and services which can be used to measure the progress of BCC programs. To monitor the progress of BCC programs, the following indicators can be used:

i. Proportion of adolescents exposed to BCC programs especially designed for adolescents such as the booklets *Nijeke Jano* and Radio the Magazine program *Jante Chai Janate Chai.*

ii. Proportion of adolescents who have heard and understood different key reproductive health messages covered by BCC programs.

iii. Proportion of adolescents who have discussed different reproductive health matters. Discussions might be with friends, peers, parent, relatives, neighbors or health care providers.

iv. Proportion of adolescents who have provided at least two correct answers about modes of transmission of HIV/AIDS.

v. Proportion of adolescents who have provided at least two correct answers about ways of preventing HIV/AIDS

vi. Proportion of adolescents having at least two correct answers about modes of transmission of STIs other than HIV/AIDS.

vii. Proportion of adolescents having at least two correct answers about ways of preventing STIs.

viii. Proportion of adolescents having knowledge of uses of condoms as preventive measure of STIs and as well as FP method.

In the light of the discussion on major findings, the following recommendations are made:

- Since exposure to media, particularly to television and radio, is quite high among adolescents, BCC activities may be undertaken in order to provide information as well as to dispel myths and misperceptions using various communication strategies such as, objective means like; booklets, television and radio serials, leaflets, as well as subjective means like; peer leaders, health providers etc.

- Seminars, exchange of dialogues and conversations and meeting with gate-keepers may be arranged in order to promote discussions about reproductive health matters at national/sub-national and local levels.

- Information on negative aspects of early marriage and early pregnancy on health and well being of adolescents, especially females may be provided to parents, community and religious leaders.

- Parents be provided with information as well and encouraged to hold positive attitudes towards the need for adolescents to know about reproductive health-related issues.

- A youth-friendly health service system should be clearly defined and developed.

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APPENDIX A

QUESTIONNAIRE FOR SURVEY OF ADOLESCENT

Cluster No. | | | |

SURVEY OF ADOLESCENT REPRODUCTIVE HEALTH INTERVENTIONS IN BANGLADESH (SARHI-1) - 2001

ADOLESCENT QUESTIONNAIRE
(Baseline Survey)

BANGLADESH CENTER FOR COMMUNICATION PROGRAMS (BCCP)

ASSOCIATES FOR COMMUNITY AND POPULATION RESEARCH (ACPR)

SURVEY OF ADOLESCENT REPRODUCTIVE HEALTH INTERVENTIONS (SARHI-1)
ADOLESCENT QUESTIONNAIRE (Baseline Survey)

Face sheet

SAMPLE IDENTIFICATION

DIVISION: _____ ☐

DISTRICT: _____ ☐☐

THANA: _____ ☐☐

UNION/WARD: _____ ☐☐

MOUZA/MAHOLLA: _____ ☐☐☐

VILLAGE/MAHOLLA: _____

STRATUM (Urban =1, Rural = 2) ☐

CLUSTER NUMBER: ☐☐☐

HOUSEHOLD NUMBER ☐☐☐

A. NAME OF ADOLESCENT: _____

B. LINE NUMBER: ☐☐

C. ADOLESCENT FATHER'S/ HUSBAND'S NAME : _____

D. NAME OF HOUSEHOLD HEAD: _____

E. AGE OF ADOLESCENT: ☐☐

F. SEX OF ADOLESCENT: Male 1 Female 2

G. MARITAL STATUS: C M 1 FM 2 NM 3

H. DATE OF LISTING: ☐☐ ☐☐ ☐☐☐☐

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY ☐☐
				MONTH* ☐☐
				YEAR 2 0 0 2
INTERVIEWER'S NAME				INT.CODE ☐☐☐
RESULT CODE**				RESULT CODE** ☐
NEXT VISIT: DATE				TOTAL NO. OF VISITS ☐
TIME				

**RESULT CODES :

1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 RESPONDENT INCAPACITATED
6 AGE UNDER 13 / OVER 19
7 OTHER _____ (SPECIFY)

MALE SUPERVISOR	FEMALE SUPERVISOR	OFFICE EDITOR	KEYED BY
NAME _____ ☐☐	NAME _____ ☐☐	☐☐	☐☐
DATE _____	DATE _____		

INFORMED CONSENT FOR PARENTS/GURDIAN
(Please read out to Father/Mother/Guardian)

Hello. My name is_____. I am an Interviewer. I am working in a private research organization named Associates for Community and Population Research (ACPR). ACPR is undertaking a survey for Bangladesh Center for Communication Programs (BCCP) and sponsored by USAID. I am assigned to collect information from your son/daughter/daughter-in-law.

The provision of health care services for adolescents aged 13-19 is very limited. Like others, adolescents also face health problems that require proper attention and care. The objective of this study is to assess knowledge, attitude and practices of reproductive health among adolescents aged 13-19. Now I would like to interview your son/daughter/daughter-in-laws …… (name) as he/she has been selected as a respondent. I intend to interview other adolescents of your locality. Now I would like to seek your permission to interview …….. (name). If you permit I shall conduct an interview for about 30-40 minutes.

Will you permit ?

Permitted .....1 Not Permitted.....2 —<END

INFORMED CONSENT FOR ADOLESCENT
(Please read out to Adolescents)

Hello. My name is_____. I am an Interviewer. I am working in a private research organization named Associates for Community and Population Research (ACPR). ACPR is undertaking a survey for Bangladesh Center for Communication Programs (BCCP) and sponsored by USAID. I am assigned for data collection.

The objective of the study is to assess knowledge, attitude, and practices of reproductive health among adolescent's aged 13-19. You have been selected to give an interview. I would also like to interview other adolescent of your locality. The information that you provide will be used for formulating an appropriate health policy.

At the time of interviewing, whatever information you provide will be kept strictly confidential and will not be shown to other persons. But if you like, you can discuss about this with your parents. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

May I begin the interview now?

RESPONDENT AGREES TO BE INTERVIEWED 1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED..... 2 —<END

Section 1

SOCIO-ECONOMIC CHARACTERISTICS

Starting Time:……

	QUESTION	RESPONSE	SKIP
101	Please tell your name?	Name:_____	
102	Sex of respondent.	Male..... 1 Female 2	
102a	**INTERVIEWER: CHECK F OF FACE SHEET AND CODE OF QUESTION 102 AND ENCIRCLE THE APPROPRIATE CODE.**	**Same code circled in F and Q102 .. 1** **Different code circled in F and 102..... 2**	**➢103**
102b	**INTERVIEWER: IN CASE OF INCONSISTENCIES, BETWEEN FACE SHEET'S SEX CODE AND RESPONDENT'S SEX CHECK WHETHER YOU REACH CORRECT SAMPLE HOUSEHOLD AND INFORM TO SUPERVISOR.**		
103	In which day, month and year were you born?	L___l___l l___l___l l___l___l DAY MONTH YEAR Don't know 97	
103a	How old were you at your last birthday? **IN CASE OF INCONSISTENCIES, CLARIFY WITH RESPONDENT AND CORRECT Q: 103 AND/OR Q: 103a.**	Years old l___l___l (Completed year)	
104	CHECK Q.103a AND ENCIRCLE THE APPROPRIATE CODE.	Age under 13 ..... 1 Age above 19 ..... 2 Age 13-19 years 3	➢Terminate Interview
105	What is your religion?	Islam..... 1 Hinduism..... 2 Christian..... 3 Buddhism ..... 4 Other_____..... 5 (Specify)	
106	Have you ever-attended school?	Yes ..... 1 No..... 2	➢106d
106a	Are you currently attending regular school/ college?	Yes ..... 1 No..... 2	➢106c
106b	What class have you passed?	☐☐ Class	➢ 106d
106c	What class do you read in currently?	☐☐ Class	
106d	**CHECK Q.106 or 106b or 106c AND ENCIRCLE THE APPROPRIATE CODE.**	Never attended school..... 1 05 or below classes ..... 2 06 or above classes..... 3	➢107

	QUESTION	RESPONSE	SKIP
106e	Can you read and write?	Yes, can read..... 1 Yes, can write ..... 2 Yes, can read and write..... 3 No 4	
107	Are you currently doing any work for pay?	Yes ..... 1 No..... 2	➢107b
107a	In the last 6 months have you ever worked for pay?	Yes ..... 1 No..... 2	➢108
107b	What type of work? Verbatim:_____	☐☐	
107c	How many taka did you earn in the last working month?	☐☐☐☐ Taka	
108	What is your current marital status?	Currently married ..... 1 Widow/Separated/Divorced..... 2 Unmarried..... 3	
108a	**INTERVIEWER: CHECK G OF FACE SHEET AND CODE OF 108 AND ENCIRCLE THE APPROPRIATE CODE.**	**Same code circled in G and 108 ..... 1** **Different code circled in G and 108..... 2**	

Section 2
MEDIA CONTACT

NOW I WOULD LIKE TO ASK ABOUT YOUR HABITS IN USING COMMUNICATION MEDIA SUCH AS RADIO, NEWSPAPER, MAGAZINE, FILM, ETC.

	QUESTION	RESPONSE	SKIP
201.	Do you listen to the radio?	Yes ..... 1 No 2	→ 202
201a.	How often do you listen to the radio: E**veryday/once in a week/once in a month?**	Every day ..... 1 Once a week ..... 2 Once a month ..... 3 Only enjoy games ..... 4 Other ..... 5 (Specify)	→ 201c → 202
201b	On what day do you usually listen to the radio?	Sunday ..... A Monday ..... B Tuesday ..... C Wednesday ..... D Thursday ..... E Friday ..... F Saturday ..... G When gets time/No particular day ..... H	
201c.	Where do you usually listen to the radio?	At home ..... 1 At relatives house ..... 2 At friends /neighbors house ..... 2 At a public place ..... 4 At Shop ..... 5 Other ..... 6 (Specify)	
201d.	With whom do you usually listen to the radio?	All family members ..... A Parents ..... B Brothers/Sisters ..... C Husband/Wife ..... D Friends/neighbors ..... E Other relatives ..... F Alone ..... G Other ..... X (Specify)	→ 201f
201e.	Can you listen to the radio alone?	Yes ..... 1 No 2	
201f.	What radio station do you usually listen to?	Radio Bangladesh (Dhaka,Ka Chanel) A Radio Bangladesh (Dhaka–Com.) ..... B Radio Bangladesh (Dhaka Gha) ..... C Radio Metro Wave ..... D Radio Bangladesh – Chittagong ..... E Radio Bangladesh – Khulna ..... F Radio Bangladesh – Rangpur ..... G Radio Bangladesh – Rajshahi ..... H Radio Bangladesh – Sylhet ..... I Radio Bangladesh – Barishal ..... J	

201g. At what time do you usually listen to the radio? **(Ask about each day separately)** (Code: Yes=1, No =2)								
Time	When gets time/No particular day	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Before 7 AM								
7 AM								
8 AM								
9 AM								
10 AM								
11 AM								
12 Noon								
01 PM								
02 PM								
03 PM								
04 PM								
05 PM								
06 PM								
07 PM								
08 PM								
09 PM								
10 PM								
11 PM/After 11 PM								
Late night								
When gets time/No particular day								

QUESTION	RESPONSE	SKIP
201h. What kind of radio programs do you usually like to listen to?	News ..... A Sports .....B Dramas .....C Serials ..... D Radio Magazine program .....E Music/Songs .....F Educational/Information ..... G Health related ..... H Advertise .....I Cinema dialogue.....J Family Planning related ..... K Religious programs .....L Other ..... X (Specify)	

201i	In the last 6 months, have you ever heard on radio something about: **(INTERVIWER:READ EACH ITEM)**			**IF CIRCLE IN Q.201i THEN ASK Q. 201j.** 201j. Did you easily understand _____(information)? **IF YES,** did you understand easily or somewhat easily?		
		Yes	No	Yes	Somewhat	No
1.	Physical changes during puberty (Age 10-19)	1 →	2 ↓	1	2	3
2.	Menstruation	1 →	2 ↓	1	2	3
3.	Wet dreams	1 →	2 ↓	1	2	3
4.	Sexual harassment	1 →	2 ↓	1	2	3
5.	Postponing early marriage	1 →	2 ↓	1	2	3
6.	How pregnancy occurs	1 →	2 ↓	1	2	3
7.	Postponing early pregnancy	1 →	2 ↓	1	2	3
8.	ANC/PNC	1 →	2 ↓	1	2	3
9.	Contraception/Family planning methods	1 →	2 ↓	1	2	3
10.	Tetanus toxoid	1 →	2 ↓	1	2	3
11.	How to prevent HIV/AIDS	1 →	2 ↓	1	2	3
12.	How to prevent other sexually transmitted diseases (STDs)	1 →	2 ↓	1	2	3
13.	Where to get reproductive health services	1 →	2 ↓	1	2	3

QUESTION		RESPONSE	SKIP
201k.	Have you ever heard the radio program Jante Chai Janta Chai?	Yes ..... 1 No ..... 2 →	202
201l.	Do you find this program entertaining?	Yes ..... 1 No 2	
201m.	Do you find this program informative?	Yes ..... 1 No 2	
202.	Do you watch TV?	Yes ..... 1 No ..... 2 →	203
202a.	How often do you watch TV: **Everyday/once in a week/once in a month?**	Every day ..... 1 → Once a week ..... 2 Once a month ..... 3 Only enjoy games ..... 4 → Other ..... 5 (Specify)	202c 203

QUESTION	RESPONSE	SKIP
202b. On what day do you usually watch the TV?	Sunday ..... A Monday .....B Tuesday .....C Wednesday ..... D Thursday .....E Friday .....F Saturday ..... G When gets time/No particular day ..... H	
202c. Where do you usually watch TV?	At home ..... 1 At relatives house ..... 2 At friends /neighbors house ..... 2 At a public place..... 4 At Shop..... 5 Other..... 6 (Specify)	
202d With whom do you usually watch TV?	All family members..... A Parents .....B Brothers/Sisters .....C Husband/Wife..... D Friends/neighbors .....E Other relatives .....F Alone ..... G Other..... X (Specify)	→202f
202e. Can you watch TV alone?	Yes..... 1 No..... 2	
202f. Which Bangladesh stations do you usually watch?	Bangladesh TV ..... A ETV .....B ATN Bangla ..... C Channel I ..... D	

202g. At what time do you usually watch TV? **(Ask about each day separately)** (Code: Yes=1, No =2)								
Time	When gets time/No particular day	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Before 7 AM								
7 AM								
8 AM								
9 AM								
10 AM								
11 AM								
12 Noon								
01 PM								
02 PM								
03 PM								
04 PM								
05 PM								
06 PM								
07 PM								
08 PM								
09 PM								
10 PM								
11 PM/After 11 PM								
Late night								
When gets time/No particular day								

QUESTION	RESPONSE	SKIP
202h. What kind of TV program do you usually watch?	Health related ..... A Curtoon .....B Advertise .....C Debate ..... D Wrestling .....E Magazine .....F News ..... G Sports ..... H Dramas .....I Serials .....J Religious programs ..... K Music/Songs .....L Educational/Information .....M Soap Opera ..... N Movies ..... O Quiz/Games shows .....P Talk show ..... Q Other ..... X (Specify)	

202i In the last 6 months, have you ever watched on TV something about: **(INTERVIWER: READ EACH ITEM)**			**IF CIRCLE IN Q.202i THEN ASK Q. 202j.** 202j. Did you easily understand _____(information)? **IF YES,** did you understand easily or somewhat easily?		
	Yes	No	Yes	Somewhat	No
1. Physical changes during puberty (Age 10-19)	1 →	2 ↓	1	2	3
2. Menstruation	1 →	2 ↓	1	2	3
3. Wet dreams	1 →	2 ↓	1	2	3
4. Sexual harassment	1 →	2 ↓	1	2	3
5. Postponing early marriage	1 →	2 ↓	1	2	3
6. How pregnancy occurs	1 →	2 ↓	1	2	3
7. Postponing early pregnancy	1 →	2 ↓	1	2	3
8. ANC/PNC	1 →	2 ↓	1	2	3
9. Contraception/Family planning methods	1 →	2 ↓	1	2	3
10. Tetanus toxoid	1 →	2 ↓	1	2	3
11. How to prevent HIV/AIDS	1 →	2 ↓	1	2	3
12. How to prevent other sexually transmitted diseases (STDs)	1 →	2 ↓	1	2	3
13. Where to get reproductive health services	1 →	2 ↓	1	2	3

QUESTION			RESPONSE			SKIP
203.	In the last six months, have you watch any video related to adolescence health?		Yes ..... 1 No ..... 2 →			204
203a	In the last 6 months, have you ever watched in the video something about: **(INTERVIWER: READ EACH ITEM)**		**IF CIRCLE IN Q.203a THEN ASK Q. 203b.** 203b. Did you easily understand _____(information)? **IF YES,** did you understand easily or somewhat easily?			
		Yes / No	Yes	Somewhat	No	
1.	Physical changes during puberty (Age 10-19)	1 → / 2 ↓	1	2	3	
2.	Menstruation	1 → / 2 ↓	1	2	3	
3.	Wet dreams	1 → / 2 ↓	1	2	3	
4.	Sexual harassment	1 → / 2 ↓	1	2	3	
5.	Postponing early marriage	1 → / 2 ↓	1	2	3	
6.	How pregnancy occurs	1 → / 2 ↓	1	2	3	
7.	Postponing early pregnancy	1 → / 2 ↓	1	2	3	
8.	ANC/PNC	1 → / 2 ↓	1	2	3	
9.	Contraception/Family planning methods	1 → / 2 ↓	1	2	3	
10.	Tetanus toxoid	1 → / 2 ↓	1	2	3	
11.	How to prevent HIV/AIDS	1 → / 2 ↓	1	2	3	
12.	How to prevent other sexually transmitted diseases (STDs)	1 → / 2 ↓	1	2	3	
13.	Where to get reproductive health services	1 → / 2 ↓	1	2	3	
204.	**INTERVIEWER: CHECK Q. 106E AND ENCIRCLE THE APPROPRIATE CODE.**		Yes, can read ..... 1 Yes, can write ..... 2 → Yes, can read and write ..... 3 No ..... 4 → No code is circled 5			207 207
205.	Have you read newspapers/magazine?		Yes ..... 1 No ..... 2 →			206

205a. In the last 6 months, have you ever read in newspapers/magazine something about: **(INTERVIWER: READ EACH ITEM)**			**IF CIRCLE IN Q.205a THEN ASK Q. 205b.** 205b. Did you easily understand _____? (information) **IF YES,** did you understand easily or somewhat easily?		
	Yes	No	Yes	Somewhat	No
1. Physical changes during puberty (Age 10-19)	1 →	2 ↓	1	2	3
2. Menstruation	1 →	2 ↓	1	2	3
3. Wet dreams	1 →	2 ↓	1	2	3
4. Sexual harassment	1 →	2 ↓	1	2	3
5. Postponing early marriage	1 →	2 ↓	1	2	3
6. How pregnancy occurs	1 →	2 ↓	1	2	3
7. Postponing early pregnancy	1 →	2 ↓	1	2	3
8. ANC/PNC	1 →	2 ↓	1	2	3
9. Contraception/Family planning methods	1 →	2 ↓	1	2	3
10. Tetanus toxoid	1 →	2 ↓	1	2	3
11. How to prevent HIV/AIDS	1 →	2 ↓	1	2	3
12. How to prevent other sexually transmitted diseases (STDs)	1 →	2 ↓	1	2	3
13. Where to get reproductive health services	1 →	2 ↓	1	2	3

206.	Do you read health related book?			Yes..... 1 No..... 2 → 207		
206a.	In the last 6 months, have you ever read in newspapers something about: **(INTERVIWER: READ EACH ITEM)**			**IF CIRCLE IN Q.206a THEN ASK Q. 206b.** 206b. Did you easily understand _____(information)? **IF YES,** did you understand easily or somewhat easily?		
		Yes	No	Yes	Somewhat	No
1.	Physical changes during puberty (Age 10-19)	1 →	2 ↓	1	2	3
2.	Menstruation	1 →	2 ↓	1	2	3
3.	Wet dreams	1 →	2 ↓	1	2	3
4.	Sexual harassment	1 →	2 ↓	1	2	3
5.	Postponing early marriage	1 →	2 ↓	1	2	3
6.	How pregnancy occurs	1 →	2 ↓	1	2	3
7.	Postponing early pregnancy	1 →	2 ↓	1	2	3
8.	ANC/PNC	1 →	2 ↓	1	2	3
9.	Contraception/Family planning methods	1 →	2 ↓	1	2	3
10.	Tetanus toxoid	1 →	2 ↓	1	2	3
11.	How to prevent HIV/AIDS	1 →	2 ↓	1	2	3
12.	How to prevent other sexually transmitted diseases (STDs)	1 →	2 ↓	1	2	3
13.	Where to get reproductive health services	1 →	2 ↓	1	2	3

QUESTION		RESPONSE	SKIP
207.	Have you attended any adolescent health related meeting in the last 6 months?	Yes..... 1 No..... 2 → 301	
207a.	What organizations/meetings have you attended?	Health related group discussion..... A School Organizations.....B Youth club .....C Religious Organizations ..... D Social Clubs.....E Boy/Girl Scouting .....F Other..... X	

QUESTION		RESPONSE			SKIP
207b. In the last 6 months, have you ever heard in meeting something about: **(INTERVIWER: READ EACH ITEM)**		**IF CIRCLE IN Q.207b THEN ASK Q. 207c.** 207c. Did you easily understand _____(information)? **IF YES,** did you understand easily or somewhat easily?			
	Yes / No	Yes	Somewhat	No	
1. Physical changes during puberty (Age 10-19)	1 → / 2 ↓	1	2	3	
2. Menstruation	1 → / 2 ↓	1	2	3	
3. Wet dreams	1 → / 2 ↓	1	2	3	
4. Sexual harassment	1 → / 2 ↓	1	2	3	
5. Postponing early marriage	1 → / 2 ↓	1	2	3	
6. How pregnancy occurs	1 → / 2 ↓	1	2	3	
7. Postponing early pregnancy	1 → / 2 ↓	1	2	3	
8. ANC/PNC	1 → / 2 ↓	1	2	3	
9. Contraception/Family planning methods	1 → / 2 ↓	1	2	3	
10. Tetanus toxoid	1 → / 2 ↓	1	2	3	
11. How to prevent HIV/AIDS	1 → / 2 ↓	1	2	3	
12. How to prevent other sexually transmitted diseases (STDs)	1 → / 2 ↓	1	2	3	
13. Where to get reproductive health services	1 → / 2 ↓	1	2	3	

Section 3

ATTITUDE TOWARDS MARRIAGE AND PREGNANCY

LET US TALK ABOUT MARRIAGE

	QUESTION	RESPONSE	SKIP
301.	In your opinion, at what age should a man ideally get married?	Year ☐☐	
302.	In your opinion, at what age should a woman ideally get married?	Year ☐☐	
303.	At what age a girl should have her first baby? At what age a boy should have her first baby?	Girl ☐☐ Boy ☐☐	
304.	How long do you think a woman should wait after one birth before she has another child?	Year ☐	
305.	**CHECK Q.108 AND ENCIRCLE THE APPROPRIATE CODE.**	**Currently married ..... 1** **Widow/Separated/Divorced ..... 2** **Unmarried 3**	**307**
306.	At what age do you expect to get married?	☐☐ When parents give 95	401
307.	How old were you when you got married?	Years ☐☐	
307a.	When you got married, do you think you were married: at too young or at the right age or older than right age?	Too young ..... 1 At the right age ..... 2 Older than right age 3	307c
307b.	What caused you to marry at too young an age?	Forced by parent ..... A Financial difficulty ..... B Tradition ..... C Own preference ..... D Pregnancy ..... E Other ..... X (Specify)	
307c.	Who is the person that most influenced the choice of your partner?	Self ..... 01 Parents ..... 02 Respondent's family ..... 03 Respondent's partner's family ..... 04 Relative ..... 05 Boyfriend/girlfriend/partner ..... 06 Friend ..... 07 Other ..... 95 (Specify)	

Section 4

FERTILITY PREFERENCES AND CURRENT FERTILITY

NOW I WOULD LIKE TO ASK YOU A FEW QUESTION ABOUT THE NUMBER OF CHILDREN YOU WOULD EVENTUALLY LIKE TO HAVE

	QUESTION	RESPONSE	SKIP
401 .	How many boys and girls would you like to have?	Boy ☐ Girl ☐ Any ☐ No children want ..... 4 God knows..... 5 Other..... 6	
402.	**INTERVIWER: CHECK Q.305 AND ENCIRCLE THE APPROPRIATE CODE.**	**Currently married..... 1** **Widow/Separated/Divorced..... 2** **Unmarried..... 3**	→ 501
402a.	**INTERVIWER: CIRCLE CODE ACCORDING TO THE RESPONDENT'S SEX.**	**Male ..... 1** **Female 2**	→ 408
403.	Have you ever been pregnant?	Yes..... 1 No..... 2	→ 408
403a.	Are you currently pregnant?	Yes..... 1 No..... 2 Uncertain 3	
404.	How old were you when you were pregnant for the first time?	☐☐ Years	
405.	How many children do you have? IF NONE WRITE 0.	☐ Son ☐ Daughter	
406.	During your last/this pregnancy, did you have one or more prenatal care visits to a medical facility?	Yes..... 1 No..... 2	
407.	What was the consequence of that pregnancy?	Live birth ..... 1 Currently pregnant..... 2 Still birth..... 3 Abortion ..... 4 MR..... 5	→ 501 → 408
407a.	Within six weeks of your last live birth, did you have one or more postnatal care visits to a medical facility?	Yes..... 1 No..... 2	
408.	Are you or your spouse currently doing (or using) anything to avoid having children?	Yes..... 1 No..... 2	→ 409
408a.	What are you or your spouse currently doing (or using) to avoid having children? **(SINGLE RESPONSE)**	Pill ..... 01 Condom ..... 02 Contraceptive injection..... 03 IUD..... 04 Norplant..... 05 Safe period..... 06 Withdrawal ..... 07 Other..... 95 (Specify)	→ 501

QUESTION		RESPONSE	SKIP
408b.	Where did you go to get contraceptive device for the last time?	Government Hospital ..... 01 Govt. clinic/Community clinic ..... 02 Govt. satellite clinic ..... 03 Fieldworker ..... 04 Private Hospital/clinic ..... 05 Private Doctor ..... 06 NGO clinic ..... 07 NGO satellite clinic ..... 08 Drug Store / Pharmacy ..... 09 Traditional healer ..... 10 Friends/family ..... 11 Other ..... 95 (Specify)	→501
409	What is the main reason why you or your husband/ wife is not currently doing (or using) anything to avoid having children?	**FERTILITY-RELATED REASONS** Infrequent sex ..... A Lactational amenorrhoea ..... B Breast-feeding ..... C Believe in luck ..... D **OPPOSITION TO USE** Respondent opposed ..... E Spouse opposed ..... F Others opposed ..... G Religious prohibition ..... H **LACK OF KNOWLEDGE** Knows no method ..... I Knows no source ..... J **METHOD-RELATED REASONS** Health concern ..... K Side effect/Fear of side effects ..... L Lack of access/too far ..... M Cost too much ..... N Inconvenient to use ..... O Hampers normal physiological process ..... P Wants child ..... Q Husband/wife away ..... R OTHER_____ .. X (Specify)	

Section 5

SEXUAL AND REPRODUCTIVE HEALTH

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS RELATING TO REPRODUCTIVE HEALTH

	QUESTION	RESPONSE	SKIP
501.	Have you ever talked with anybody about changes menstruation, wet dream during puberty?	Yes ..... 1 No 2	→ 501b
501a.	Who are the persons you often talk with about changes during puberty?	Father ..... A Mother ..... B Sister/ Brother ..... C Sister In-Law/ Brother In-Law ..... D Spouse ..... E Teacher/religion teacher ..... F Friends/boyfriend/girlfriend/fiancée ... G Other relative ..... H Grandfather/grandmother ..... I Family planning fieldworker ..... J Physician/paramedic ..... K Dai ..... L Traditional Healer ..... M Canvesser ..... N Pharmacist ..... O Other ..... X (Specify)	
501b.	Do you think it is easy or difficult to obtain information about changes during puberty?	Yes ..... 1 No 2	→ 501d
501c.	Why is it difficult to obtain this information?	Don't know where to obtain information ..... A Parents disapprove ..... B Service provider disapproves ..... C Costs too much ..... D Feel shy ..... E Others don't take easily ..... F Metal hazard ..... G Other ..... X (Specify)	

QUESTION		RESPONSE	SKIP
501d.	If you want to know more about changes during puberty matters what would you do? **PROBE BY ASKING 'ANYTHING ELSE"**	Go to clinic/hospital ..... A Listen to the radio .....B Watch TV .....C Watch videos/movies ..... D Read newspapers/magazines .....E Find brochures or leaflets .....F Read books ..... G Consult with a qualified doctor ..... H Consult family planning fieldworker ...I Consult with health worker .....J Attend discussion forums ..... K Consult with a village doctor .....L Discuss with relative .....M Discuss with friend/neighbour ..... N Send question to newspaper ..... O Send letter to radio/TV .....P Other ..... X (Specify) Don't know ..... Y	
501e.	If you had a problem or question about puberty changes where would you go for help? **PROBE BY ASKING 'ANYPLACE ELSE'**	Clinic/hospital ..... A Qualified doctor .....B FP fieldworker .....C Health worker ..... D Spouse .....E Parents .....F Relatives ..... G Friend/neighbour ..... H Teacher .....I Village doctor .....J Traditional Healer..... K Other ..... X (Specify) Don't know ..... Y	
502.	Have you ever talked with anybody about pregnancy?	Yes..... 1 No..... 2	→502b
502a.	Who are the persons you talk with about pregnancy?	Father..... A Mother .....B Sister/ Brother.....C Sister In-Law/ Brother In-Law ..... D Spouse .....E Teacher/religion teacher .....F Friends/boyfriend/girlfriend/fiancée... G Other relative..... H Grandfather/grandmother .....I Family planning fieldworker .....J Physician/paramedic..... K Dai .....L Traditional Healer.....M Canvesser ..... N Pharmacist ..... O Other..... X (Specify)	
502b.	Do you think it is easy or difficult to obtain information about pregnancy?	Yes ..... 1 No 2	→ 502d

QUESTION		RESPONSE	SKIP
502c.	Why is it difficult to obtain this information?	Don't know where to obtain information ..... A Parents disapprove..... B Service provider disapproves..... C Costs too much ..... D Feel shy ..... E Others don't take easily..... F Metal hazard ..... G Other..... X (Specify)	
502d.	If you want to know more about pregnancy matters what would you do? **PROBE BY ASKING 'ANYTHING ELSE"**	Go to clinic/hospital ..... A Listen to the radio ..... B Watch TV ..... C Watch videos/movies ..... D Read newspapers/magazines ..... E Find brochures or leaflets ..... F Read books ..... G Consult with a qualified doctor ..... H Consult family planning fieldworker ... I Consult with health worker ..... J Attend discussion forums ..... K Consult with a village doctor ..... L Discuss with relative ..... M Discuss with friend/neighbour ..... N Send question to newspaper ..... O Send letter to radio/TV ..... P Other ..... X (Specify) Don't know ..... Y	
502e.	**(ONLY FOR FEMALE)**If you had a pregnancy related problem or question, where would you go for help? **PROBE BY ASKING 'ANYPLACE ELSE'**	Clinic/hospital ..... A Qualified doctor ..... B FP fieldworker ..... C Health worker ..... D Spouse ..... E Parents ..... F Relatives ..... G Friend/neighbour ..... H Teacher ..... I Village doctor ..... J Traditional Healer..... K Other ..... X (Specify) Don't know ..... Y	

Section 6

HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES

I WOULD LIKE TO ASK SEVERAL QUESTIONS ON HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES (STDs).

QUESTION	RESPONSE	SKIP
601. Have you ever heard about HIV/AIDS ?	Yes ..... 1 No ..... 2 →	602
601a. Where did you heard about HIV/AIDS? **PROBE, ANYTHING ELSE ?**	Radio ..... A TV ..... B Newspaper/magazine ..... C Brochure/Poster/leaflet /Wall magazine ..... D Health worker ..... E Family Planning Worker ..... F Mosque/church/temple ..... G School/Teacher ..... H Community gathering ..... I Friend/Relative ..... J Work place ..... K Scout meeting ..... L Science Book ..... M Family health/Smiling sun clinic ..... N Other ..... X (Specify)	
601b. How do you think one can be infected with HIV/AIDS? **PROBE, ANYTHING ELSE?**	Sexual intercourse with a sufferer ..... A Sexual intercourse with sex worker ..... B Sexual intercourse with many partners ..... C Sexual intercourse with people of the same sex ..... D Not using condom during intercourse ..... E Receive blood transfusion ..... F From an non-sterile needle/syringe ..... G A baby born from an HIV mother ..... H Use other's razor/blade ..... I Kissing ..... J Exchange underwear with others ..... K Using public rest room /toilet ..... L Lack of nutrition ..... M Other ..... X (Specify) Don't know ..... Y	

	QUESTION	RESPONSE	SKIP
601c.	Is there anything a person can do to avoid getting HIV/AIDS?	Abstain from sex ..... A Not to have any association with a Sufferer ..... B Use a condom before having sexual Intercourse ..... C Limit sex within marriage ..... D Limit sex with trusted partner ..... E Avoid sex with a sex worker ..... F Avoid sex with persons who have many partners ..... G Avoid sex with homosexuals ..... H Not to have sexual intercourse with different people ..... I Avoid sex with persons who inject drugs intravenously ..... J Avoid unsafe blood transfusions ..... K Avoid unsterilized needles/syringe ..... L Avoid kissing ..... M Avoid using public rest room /toilet ..... N Avoid habit of exchanging underwear with others ..... O Take antibiotics before having sexual intercourse ..... P Avoid mosquito bites ..... Q Seek protection from traditional healer ..... R Avoid sharing razors/blades ..... S Other ..... X (Specify)	
601d.	**INTERVIEWER:CHECK Q601b AND ENCIRCLE THE APPROPRIATE CODE.**	**Not circled in code C or D ..... 1** **Circled in code C or D or both 2**	→ **601g**
601e.	In your opinion, is there any chance of getting HIV/AIDS for a person with multiple sexual partners?	Yes ..... 1 No ..... 2 Don't know 8	▶ 601g
601f.	If a person has sex with only one partner, does this person have a greater or a lesser chance of getting HIV/AIDS than a person who has sex with many partners?	Greater chance of HIV/AIDS ..... 1 Lesser chance of HIV/AIDS ..... 2 Don't know 8	
601g.	Is it possible for a healthy looking person to have the HIV/AIDS virus?	Yes ..... 1 No ..... 2 Don't know 8	
601h.	Do you think HIV/AIDS is curable?	Yes ..... 1 No ..... 2 Don't know 8	
602.	Have you ever heard about (except HIV/AIDS) sexually transmitted diseases (STD)?	Yes ..... 1 No 2	→ 603
602a.	What are those? **PROBE, ANYTHING ELSE?**	Gonorrhea ..... A Syphilis ..... B Other ..... X (Specify)	

QUESTION		RESPONSE	SKIP
602b.	Where did you heard about _____? (answer of q602a) **PROBE, ANYTHING ELSE ?**	Radio ..... A TV ..... B Newspaper/magazine..... C Brochure/Poster/leaflet /Wall magazine..... D Health worker..... E Family Planning Worker ..... F Mosque/church/temple ..... G School/Teacher..... H Community gathering..... I Friend/Relative ..... J Work place ..... K Scout meeting..... L Science Book..... M Family health/Smiling sun clinic..... N Canvassor ..... N Other..... X (Specify)	
602c.	Have you ever talked with anybody about sexually transmitted diseases (STD)?	Yes..... 1 No..... 2	→602e
602d.	Who are the persons you often talk with about sexually transmitted diseases (STD)?	Father..... A Mother ..... B Sister/ Brother ..... C Sister In-Law/ Brother In-Law ..... D Spouse ..... E Teacher/religion teacher..... F Friends/boyfriend/girlfriend/fiancée..... G Other relative..... H Grandfather/grandmother ..... I Family planning fieldworker ..... J Physician/paramedic..... K Dai ..... L Traditional Healer..... M Canvasser ..... N Pharmacist ..... O Other..... X (Specify)	
602e.	Do you think it is easy or difficult to obtain information about STD?	Yes ..... 1 No 2	→602g
602f.	Why is it difficult to obtain this information?	Don't know where to obtain information ..... A Parents disapprove..... B Service provider disapproves ..... C Costs too much ..... D Feel shy ..... E Others don't take easily..... F Metal hazard..... G Other..... X (Specify)	

	QUESTION	RESPONSE	SKIP
602g.	In a man, what signs and symptoms would lead you to think that he has sexually transmitted diseases (STD)? **PROBE, ANY OTHERS ?**	Lower abdominal pain ..... A Discharge from penis/dripping ..... B Foul smelling discharge ..... C Burning pain on urination ..... D Redness/inflammation in genital area ..... E Swelling in genital area ..... F Genital sores/ulcers ..... G Genital warts ..... H Blood in urine ..... I Loss of weight ..... J Impotence ..... K Fever ..... L No symptoms ..... M Other_____ ..... X (Specify) Don't know ..... Y	
602h.	In a woman, what signs and symptoms would lead you to think that she has sexually transmitted diseases (STD)? **PROBE, ANY OTHERS ?**	Lower abdominal pain ..... A Genital discharge ..... B Foul smelling discharge ..... C Burning pain on urination ..... D Redness/inflammation in Genital Area ..... E Swelling in genital area ..... F Genital sores/ulcers ..... G Genital warts ..... H Blood in urine ..... I Loss of weight ..... J Inability to give birth ..... K Fever ..... L No symptoms ..... M Other_____ ..... X (Specify) Don't know ..... Y	
602i.	How do you think one can be infected with sexually transmitted diseases (STD)?	Sexual intercourse with a sufferer ..... A Sexual intercourse with sex worker ..... B Sexual intercourse with many partners ..... C Sexual intercourse with people of the same sex ..... D Not using condom during intercourse ..... E Receive blood transfusion ..... F From an non-sterile needle/syringe ..... G A baby born from an HIV mother ..... H Use other's rezor/blade ..... I Kissing ..... J Exchange underwear with others ..... K Using public rest room /toilet ..... L Lack of nutrition ..... M Other ..... X (Specify) Don't know ..... Y	

QUESTION		RESPONSE	SKIP
602j.	What should a person do if infected with sexually transmitted diseases (STD)?	Nothing, because he/she will die soon and there is no medicine to cure it. ..... A Take antibiotics. .....B Consult with government hospital/clinic. .....C Consult with private practitioner/ nurse/midwife. ..... D Go to medicine man/traditional healer. .....E Rest.....F Not transmit it to healthy others. ..... G Pray. ..... H Moral support from family/friend.....I .Not remaining alone .....J Other_____ ..... X (Specify) Don't know ..... Y	
602k.	Is there anything a person can do to avoid getting sexually transmitted diseases (STD)?	Abstain from sex ..... A Not to have any association with a Sufferer.....B Use a condom before having sexual Intercourse.....C Limit sex within marriage ..... D Limit sex with trusted partner.....E Avoid sex with a sex worker .....F Avoid sex with persons who have many partners ..... G Avoid sex with homosexuals..... H Not to have sexual intercourse with different people .....I Avoid sex with persons who inject drugs intravenously .....J Avoid unsafe blood transfusions ..... K Avoid unsterilized needles/syringe.....L Avoid kissing .....M Avoid using public rest room /toilet ..... N Avoid habit of exchanging underwear with others ..... O Take antibiotics before having sexual intercourse .....P Avoid mosquito bites..... Q Seek protection from traditional healer .....R Avoid sharing razors/blades ..... S Other..... X (Specify) Don't know ..... Y	

	QUESTION	RESPONSE	SKIP
602l.	If you want to know more sexually transmitted diseases (STD)matters what would you do? **PROBE BY ASKING 'ANYTHING ELSE"**	Go to clinic/hospital ..... A Listen to the radio .....B Watch TV .....C Watch videos/movies ..... D Read newspapers/magazines .....E Find brochures or leaflets .....F Read books ..... G Consult with a qualified doctor ..... H Consult family planning fieldworker .....I Consult with health worker .....J Attend discussion forums ..... K Consult with a village doctor .....L Discuss with relative .....M Discuss with friend/neighbour ..... N Send question to newspaper ..... O Send letter to radio/TV .....P Other ..... X (Specify) Don't know ..... Y	
602m.	If you have any STD problem or question, where would you go for help? **PROBE BY ASKING 'ANYPLACE ELSE'**	Clinic/hospital ..... A Qualified doctor .....B FP fieldworker .....C Health worker ..... D Spouse .....E Parents .....F Relatives ..... G Friend/neighbour ..... H Teacher .....I Village doctor .....J Traditional Healer..... K Other ..... X (Specify) Don't know ..... Y	
602n.	Is it possible for a healthy looking person to have the sexually transmitted diseases (STD)?	Yes ..... 1 No..... 2 Don't know 8	
603.	**INTRVIWER:CHECK Q408a AND EN CIRLE THE APPROPRIATE CODE.**	**Code 02 is circled ..... 1** **Other Codes are circled except code 02.... 2** **No code is circled 3**	→**604a**
604.	Have you heard about condom?	Yes ..... 1 No..... 2	→605
604a.	What are the reasons for using condom?	Contraception ..... A Safe from STDs.....B Safe from HIV/AIDS.....C Other ..... X (Specify)	
604b.	If a person uses a condom every time he or she has sexual intercourse, does this person have a greater or a lesser chance of getting HIV/AIDS than someone who doesn't use a condom?	Greater chance of HIV/AIDS ..... 1 Lesser chance of HIV/AIDS..... 2 Don't know 8	
605.	**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.**		

Finishing Time:…….

APPENDIX B

LIST OF PERSONNEL WHO PARTICIPATED IN THE STUDY

LIST OF PERSONNEL WHO PARTICIPATED IN THE STUDY

A. Key Personnel

Dr. M. Sekander Hayat Khan
Principal Investigator

Mr. A P M Shafiur Rahman
Mr. Nitai Chakroborty
Co-Principal Investigator

Ms. Tauhida Nasrin
Field Coordinator

B. Administrative Staff

Ms. Rezina Sultana
Accounts cum Administrative Officer
Ms. Nurun Nahar
Secretary

C. Data processing Staff

Mr. Kh. Kairul Bashar
Data Processing Supervisor
Editor cum Coder
Ms. Mahfuza Begum
Ms. Mafruha Gulnoor
Mr. Pijush Kumar Bhattacharjee
Mr. Mir Yusuf Kamal
Ms. Dilruba Akhter
Ms. Sharmin Rahman
Registration/Documentation Officer
Ms. Asma Huq
Data Entry Operator
Mr. Saiful Islam
Ms. Nurun Nahar
Ms. Shahin Akhter
Mr. Md. Monir Uddin
Mr. Md. Kamruzzaman
Mr. Md. Sanwar Hissain
Mr. Md. Abdul Aziz
Mr. Md. Hossain

D Quality Control Officer (Enumeration)

Mr. Sharif Al Hasan
Mr. Zahed Shafiqur Razzak
Mr. Ehosan Ali Mollah

E Quality Control Office (Data Collection)

Mr. Sharif Al Hasan
Mr. Zahed Shafiqur Razzak
Mr. Ehosan Ali Mollah
Ms. Farzana Rahman
Ms. Shellyna Akhter Shelly
Ms. Silvia Morium Khan

F Enumerator

Mr. Mahiuddin Talukder
Mr. Mahbubur Rahman
Mr. Mr. Md. Sabur
Mr. Md. Saiful Islam Palash
Mr. Shafiuddin Mahmood
Mr. Amirul Islam Mondal
Mr. Md. Hafizur Rahman
Mr. Md. Tofazzal Hossain
Mr. Nazrul Islam
Mr. Faruk Hossain
Mr. Saiful Islam Sarker
Mr. Md. Mohor Ali
Mr. Abdus Samad

Mr. Md. Arif Hossain (1)
Mr. Abdul Mannan
Mr. F. M. Nazrul Islam
Mr. Md. Shameem Reza
Mr. Arif Hossain Sohel (2)
Mr. Parag Mahbub
Mr. Noor Mohammed Shiddiki
Mr. Md. Shariful Alam Bhuyan
Mr. Mahbubul Alam
Mr. Md. Shahin Khan

G. Male Supervisor

Mr. A T M Anwar Hossain
Mr. Md. Nazrul Islam
Mr. Md. Tauhidul Islam
Mr. Sharifullah Riaz
Mr. Md. Mahiuddin Patwari
Mr. Sattyajit Biswas
Mr. Md. Rawsan Ali
Mr. Md. Abul Kasem Mia
Md. Zakir Hossain
Mr. Faysal Ahmed
Mr. Syed Shah Noor Ali
Mr. Md. Hasan Tareq

H. Female Supervisor

Ms. Kismat Jahan Ferdousi
Ms. Rahana Begum
Ms. Mahmuda Shirin
Ms. Arju Akhter
Ms. Jannatul Ferdous Jannat
Ms. Zakrin Sultana
Ms. Sagorika Thigidi
Ms. Kanchan Mala
Ms. Humayra Taslim
Ms. Daliara
Ms. Farhana Haque
Ms. Kamrun Nahar

I. Male Interviwer

Mr. Md. Ashraful Islam (1)
Mr. Md. Ataur Rahman
Mr. Gazi Md. Shawkat
Mr. Md. Mahbubur Rahman
Mr. Arif Hossain
Mr. Md. Abu Sayed
Mr. Md. Ashraful Islam(2)
Mr. Mr. Md Jahidur Rahman
Mr. Md. Abdus Samad
Mr. Md. Kamruzzaman Howlader
Mr. Rashed Md. Ali Monsur
Mr. Md Luthfor Rahman
Mr. Zogesh Ghosh
Mr. Maydul Islam Chowdhury

J. Female Interviewer

Ms. Aklima Akhter
Ms. Rowson E-Sitara
Ms. Most. Mahmuda Akhter
Ms. Sanchita Barua
Ms. Athithey Chakma
Ms. Suraiya Pervin Trishna
Ms. Mahfuza Begun
Ms. Nazma Khanam
Ms. Raunak Jahan
Ms. Kabita Biswas
Ms. Shanga Mitra Chakma
Ms. Rashida Akhter
Ms. Shirin Akhter
Ms. Dilara Begum
Ms. Nasima Akhter
Ms. Nargis Akhter
Ms. Sayda Shilpi Sultana
Ms. Champa Chamely
Ms. Karuna Chakma
Ms. Shathi Akhter
Ms. Ziaonnessa Begum
Ms. Salina Akhter
Ms. Bilkis Banu
Ms. Shamima Islam Mina
Ms. Shipra Costa
Ms. Taskin Akhter
Ms. Lovely Chakma
Ms. Nahid Akhter
Ms. Jesmin Sufia Kiron
Ms. Parvin Akhter

APPENDIX C
TABLES

Table C4.1: Percentage of adolescents by frequency and place of listening of radio programs

	Urban			Rural			National		
	Male	Female	All	Male	Female	All	Male	Female	All
Frequency of listening:									
Everyday	12.6	6.2	9.1	23.8	17.1	20.4	21.7	14.9	18.2
1 – 6 days	19.6	15.9	17.7	37.7	28.1	32.9	34.4	25.6	29.9
Less than once a week	4.1	2.2	3.1	3.0	3.3	3.1	3.2	3.1	3.1
No exposure	63.7	75.7	70.1	35.6	51.5	43.6	40.8	56.4	48.7
N	**332**	**380**	**712**	**1479**	**1494**	**2974**	**1812**	**1874**	**3686**
Place of listening:									
Own home	71.2	89.2	79.0	64.8	66.7	65.6	65.5	69.3	67.1
Relatives' house/ Neighbors house	11.1	9.4	10.4	23.7	32.7	27.6	22.3	30.0	25.6
Others	17.7	1.4	10.6	11.5	0.6	6.8	12.2	0.7	7.2
N	**120**	**92**	**213**	**953**	**725**	**1677**	**1073**	**817**	**1890**

Table C4.2: Percentage of adolescents according to frequency and place of viewing of TV program

	Urban			Rural			National		
	Male	Female	All	Male	Female	All	Male	Female	All
Frequency of viewing									
Everyday	49.3	56.3	53.0	22.4	19.7	21.1	27.4	27.1	27.2
1 – 6 days	45.7	35.5	40.2	59.7	39.1	49.4	57.1	38.4	47.6
Less than once a week	1.0	1.3	1.1	3.0	3.8	3.4	2.7	3.3	3.0
No exposure	4.0	7.0	5.6	14.8	37.3	26.1	12.8	31.2	22.2
N	**332**	**380**	**712**	**1479**	**1494**	**2974**	**1812**	**1874**	**3686**
Place of viewing									
Own home	67.5	69.4	68.5	21.2	32.5	26.0	30.6	42.6	36.0
Relatives'/Neighbours house	27.9	30.4	29.2	66.6	67.1	66.8	58.8	57.0	58.0
Others	4.6	0.2	2.3	12.2	0.4	7.2	10.7	0.4	6.0
N	**319**	**353**	**672**	**1260**	**936**	**2196**	**1579**	**1290**	**2869**

Table C6.1: Percentage of adolescents heard about STI, percentage who heard STI know specific signed symptoms of STI is men and women and know mode of transport and ways to avoid STI, according to sex and residence.

	Rural		Urban		National	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Heard about STI	4.7	3.6	7.5	5.3	5.2	4.0
N	1479	1493	333	380	1812	1872
Knowledge of specific signs or symptoms of STIs of men						
Discharge blood or puss from penis	65.9	22.2	28.0	9.4	55.7	17.5
Foul smelling discharge from penis	19.1	13.8	17.3	0.0	17.3	10.0
Genital sores/ulcers	29.7	30.5	17.3	5.6	26.9	25.0
Knowledge of specific signs or symptoms of STIs of Women						
Discharge blood or puss from genital	10.6	19.4	5.3	9.4	9.6	17.5
Foul smelling discharge from genital	4.3	13.9	4.0	1.9	3.8	10.0
Knowledge about mode of transmission of STI						
Sex with infected person	46.8	44.4	28.0	32.1	42.3	40.0
Sex with sex worker	46.8	11.1	36.0	5.7	44.2	10.0
Sex with multiple partners	14.9	22.2	34.7	26.4	19.2	22.5
Not using condom during intercourse	29.8	25.0	30.7	7.5	30.8	20.0
Knowledge about ways to avoid STI						
No sex with HIV infected partner	27.7	38.9	14.7	20.8	26.9	32.5
Use condom during sexual intercourse	21.3	44.4	21.3	30.2	25.0	40.0
Limit sex within marriage	17.0	11.1	10.7	15.1	21.2	12.5
Limit sex within trusted partner	2.1	5.6	1.3	1.9	1.9	5.0
Avoid sex with commercial sex worker	53.2	8.3	5.3	7.5	46.2	7.5
Avoid multiple-sex partners	8.5	2.8	1.3	1.9	7.7	2.5
No indiscriminate sex	22.1	8.3	0.0	0.0	1.9	7.5
N	70	54	25	20	95	74

Table C6.2: Percentage of adolescents who heard about STI by sources of information about STI.

Source of information	Percentage
Radio	21.7
TV	19.8
Print media	29.2
Health personnel	10.4
Friend/relatives	38.1
Canvasser	28.8
Others	46.1
N	169