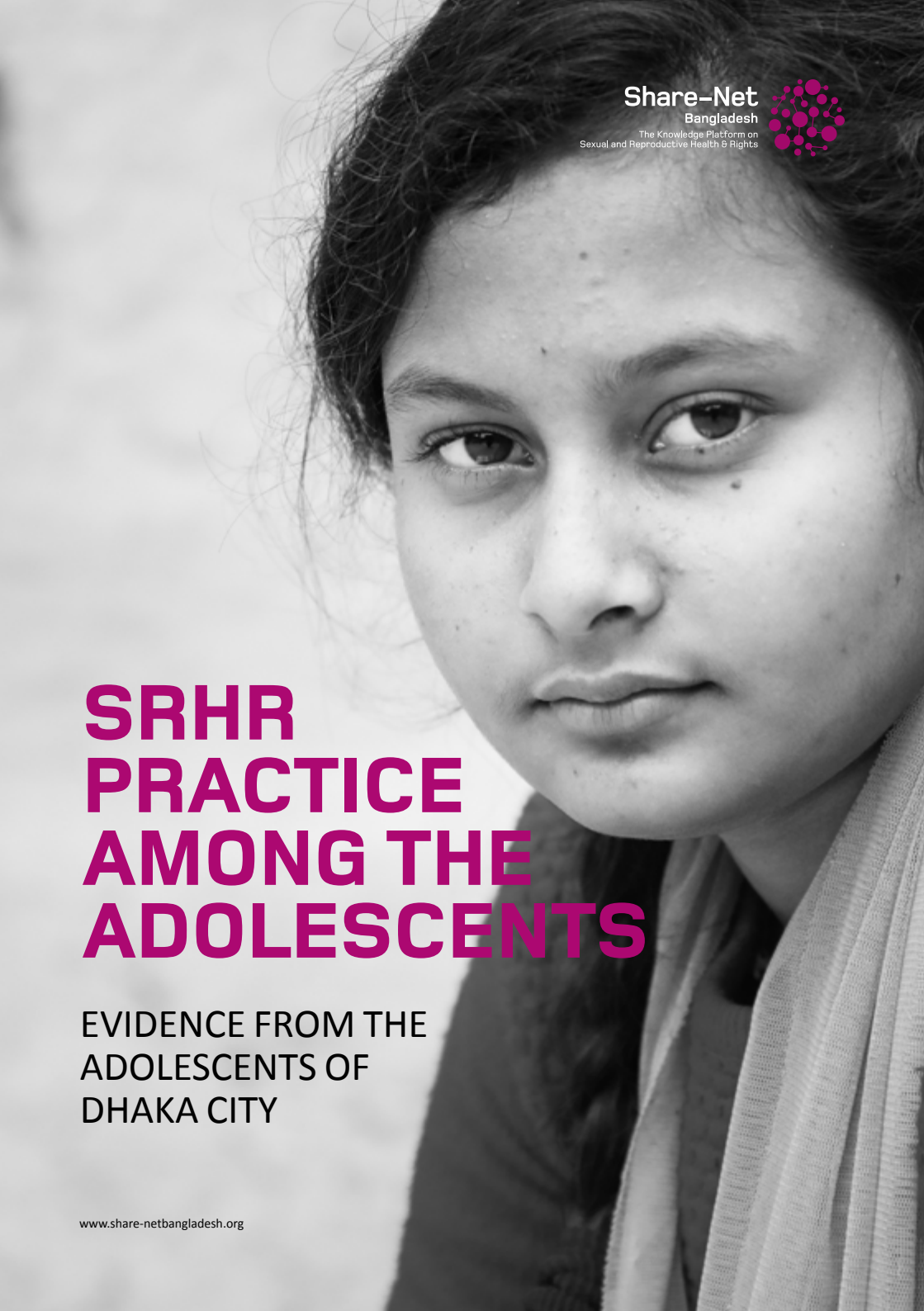

Share–Net
Bangladesh
The Knowledge Platform on
Sexual and Reproductive Health & Rights

SRHR PRACTICE AMONG THE ADOLESCENTS

EVIDENCE FROM THE ADOLESCENTS OF DHAKA CITY

www.share-netbangladesh.org

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ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
ESD	Essential Service Delivery
FGM	Female Genital Mutilation
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STDs	Sexually Transmitted Diseases

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EXECUTIVE SUMMARY

Sexual and Reproductive Health and Rights are one of the less discussed/discovered issues, at least in Bangladesh. Due to its sensitivity and varying standards from community to community, the lack of literature support led to confusions regarding the amount of knowledge available to the prospective individuals. The scenario was worse in case of the two adolescent individuals aged between twelve to thirteen. Under this scenario, this study aims to explore the state of knowledge and practice towards SRHR, the cost-benefit aspect of SRHR, and the policy level recommendations.

Methodologically this study is basically a quantitative one, but it uses FGDs and KIIs as qualitative methods to support the quantitative findings. Along with the qualitative analysis, four hundred samples have been collected as a part of quantitative survey. The participants were urban school-going adolescents aged between twelve to nineteen that included both male and female. Due to their age being less than eighteen, the consents of interviewing them were collected from their guardians. When their guardians permitted their children to be interviewed, these children received the questionnaire. This data collection was done using KoBoToolbox leading to be zero paper usage. STATA was used to analyse the survey data and presented through relevant tables. MAXQDA was used to analyse the qualitative portions, and the qualitative findings were blended within the study.

This study found that the state of knowledge and practice is not similar across the domain. The necessary knowledge is comparatively higher, but the health or pubertal status does not comply with the findings. Despite this high necessity, we have not yet been able to make all adolescents inform of the very basics of SRHR. All these are the story of the most privileged group of the society. The respondents of this study's socio-economic background possess their class denotation. The

situation might be worse for other spectra of semi-urban or rural periphery and so on. The cost-benefit analysis later reveals that more investment in SRHR interventions is beneficial for micro-macro and short-long-run perspectives. Later the rise in one perspective of SRHR has almost nothing to do with another relevant perspective.

As for the improvement of the current SRHR scenario, we need to implement stakeholder-based initiatives. At the policy level, SRHR goods subsidization, teaching these issues institutionally, and incorporating those into policy documents need to be implemented. Moreover the holistic interventions countering all the components of SRHR need to be addressed as we can not expect the betterment in one component would lead to the betterment of any other remaining component. Lastly, more comprehensive research including demographic variation, rural-urban setting, religion, and others in the sampling framework on the larger scale is an immediate need. These studies would help the stakeholders provide the exact scenario leading to more accurate SRHR knowledge and information to design and implementation of development interventions.

1. BACKGROUND

1.1 BANGLADESH: A DEMOGRAPHIC REALITY

Bangladesh is a densely populated country in comparison to its geographical area. This country is the eighth-most populated country of the world. According to the estimate of 2019, this country's total population is (Population of Countries in Asia - Place Rankings- Data Commons, n.d.) sixteen core and thirty lakh approximately.

Demographic Dynamics for Year 1960

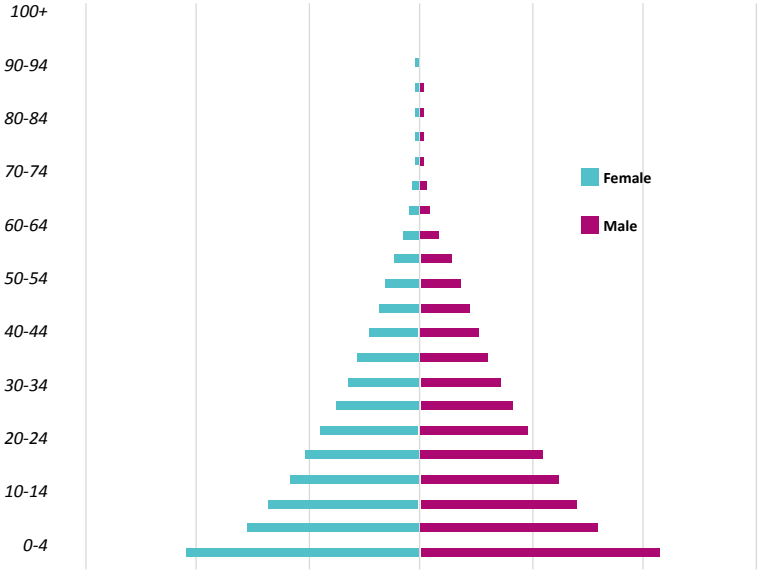


Figure 1: *Demographic Dynamics of Bangladesh 1960*

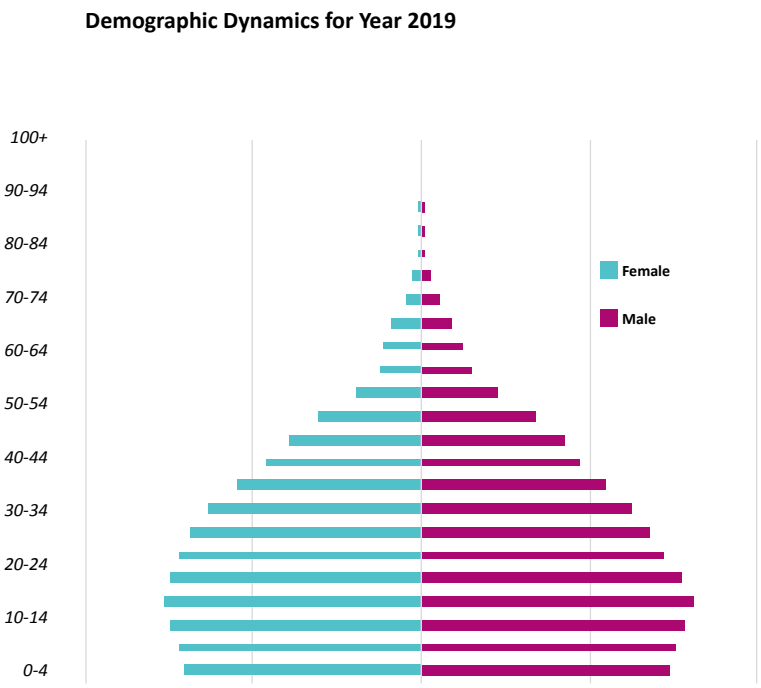
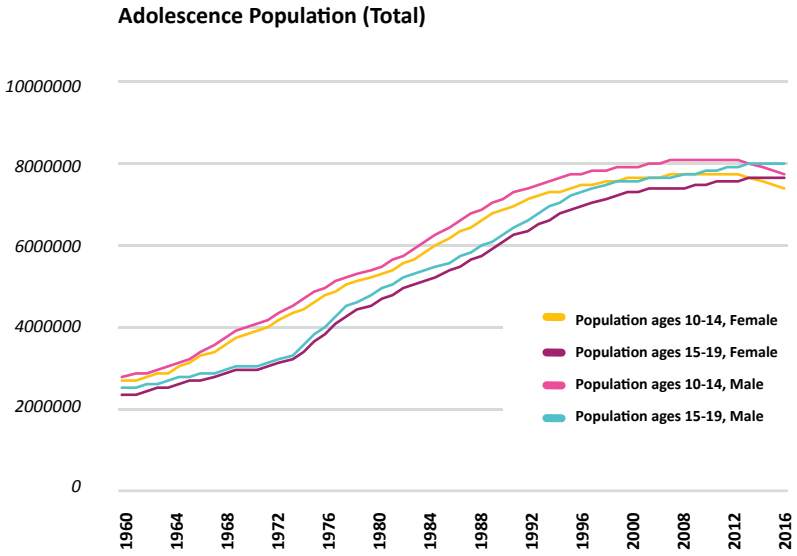


Figure 2: *Demographic Dynamics of Bangladesh 2019*

Adolescence refers to the people aged between ten to nineteen according to the World Health Organization's definition. Moreover, adolescence is divided into two different phases. They are early adolescence and late adolescence. Early adolescents refer to those aged between 10 to 14, where late adolescents refer to 15 to 19.

According to the Bangladesh Census 2011, twenty percent of the entire population is adolescent, and this percentage is expected to be so until 2030. One of this age group's unique characteristics is to be introduced to their reproductive health system.



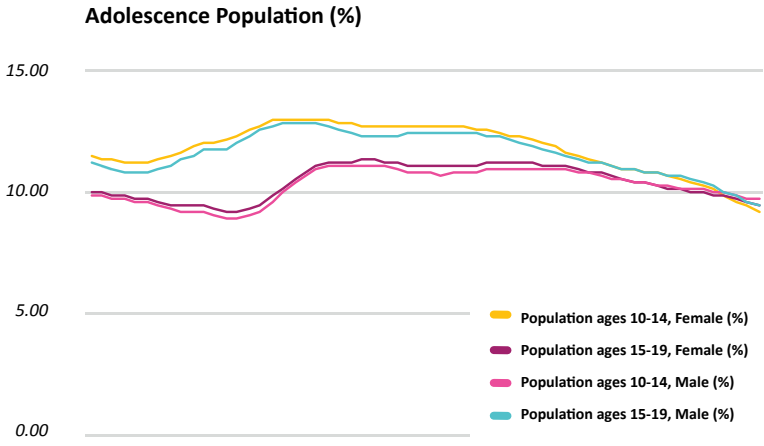


Figure 3: *Adolescence Population Dynamics*

	Population ages 10-14, female (% of female population)	Population ages 15-19, female (% of female population)	Population ages 10-14, male (% of male population)	Population ages 15-19, male (% of male population)
1960	11.52	10.04	11.23	9.92
1970	12.03	9.48	11.72	9.22
1980	12.99	11.06	12.80	10.95
1990	12.75	11.05	12.46	10.76
2000	11.99	11.14	11.81	11.01
2010	10.76	10.28	10.83	10.32
2019	9.25	9.49	9.44	9.70

Table 1: *Adolescence Population Distribution of Bangladesh: A historical point of view*

This reality can be evident from the data documented by the world bank. The population size of adolescence represented in the previous table does possess several interesting insights. Early adolescents' population size seems to rise more in the early decades and tends to fall earlier than the other counterpart of the late adolescent. Interestingly, adolescents' total contribution to the entire population is around twenty percent approximately over the years.

1.2 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND ITS COMPONENTS

SRHR stands for Sexual and Reproductive Health and Rights. This issue (Chandra-Mouli et al., 2015, p. 1) was discussed for the first time in the most comprehensive form in the International Conference on Population and Development in Cairo in 1994. This conference agenda came to action through Beijing (European Humanist Federation, 2015, p. 1) platform of action in 1995. Later this domain was (Yamin & Boulanger, 2013) incorporated into Millennium Development Goals (MDGs).

Sexual and Reproductive Health *is the ability to have a safe and satisfying sex life and the ability to reproduce.*

Sexual and Reproductive Rights *are the right for everyone to make decision about their sexual and reproductive health*

Family planning *allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.*

Reproductive Healthcare *includes family planning services, access to contraception, counselling and information, antenatal, postnatal and delivery care, health care for infants, treatment for reproductive tract infections and sexually transmitted diseases (including HIV/AIDS), safe abortion services where legal and management of abortion-related complications, prevention and appropriate treatment for infertility, information, education and counselling on human sexuality, reproductive health and responsible parenting and discouragement of harmful practices.*

Despite many efforts since its inception, a severe knowledge gap is observed of this issue. Even though serious interventions are needed for better SRHR issues, all the interventions must not be homogenous. For example, comprehensive (Hoctor & Lamačková, 2017, p. 33) sexual education and the right to safe (Hoctor & Lamačková, 2017, p. 28) abortion is one of the most demanded thematic areas. However, this is irrelevant, at least from first-order consideration for the Sub-Saharan or South Asian Region. SRHR is (International Planned Parenthood Federation, n.d.; Starrs, Ezeh, Barker, Basu, Bertrand, Blum, Coll-Seck, Grover, Laski, & Roa, 2018) presumed as one of the keys of gender equality and women empowerment.

SL. No.	List of some Sexual and Reproductive Rights
1	The Right to Life
2	The Right to Liberty and Security of the Person
3	The Right to Equality, and to be Free from all Forms of Discrimination
4	The Right to Privacy
5	The Right to Freedom of Thought
6	The Right to Information and Education
7	The Right to Choose Whether or Not to Marry and to Found and Plan a Family
8	The Right to Decide Whether or When to have Children
9	The Right to Health Care and Health Protection
10	The Right to the Benefits of Scientific Progress
11	The Right to Freedom of Assembly and Political Participation
12	The Right to be Free from Torture and Ill-Treatment

Table 2: *List of some Sexual and Reproductive Rights*

Source: ***I****PPF Charter Guidelines on Sexual and Reproductive Rights (Newman & Helzner, 1999)*

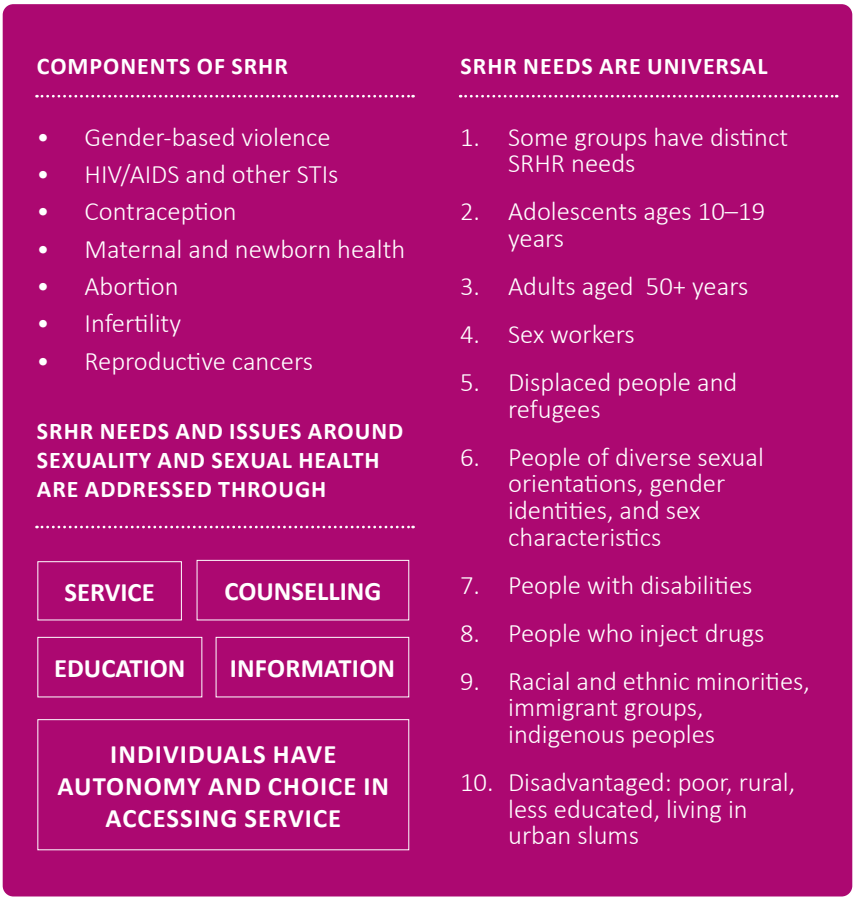


Figure 4: *SRHR Mapping*

Unfortunately, unsafe sex has been (Glasier et al., 2006) the second most important risk factor for disability and death in the world's most impoverished communities and the ninth most important in developed countries. The better scenario in the context of SRHR can make it easier to fight with STDs comparatively. The young people should (Braeken & Rondinelli, 2012, p. 1) be provided SRHR more holistically. This SRHR

knowledge domain is (Wood & Aggleton, 2003) the safe pass route for a young person to adulthood.

For a better SRHR scenario, two-fold policy intervention has (Germain et al., 2016, p. 148) already been proposed. The first one is to transform population policies to achieve human development equity and rights. The other one is to put sexuality and gender relation to the center of the population problems.

1.3 SRHR AND ADOLESCENCE

SRHR as a whole is (Åkerman et al., 2019, p. 65) important to gender equality and women's health and survival due to its impact on maternal, newborn, child, and adolescent and economic development. According to the global estimate of 2020, 200 million girls and women are (The Lancet Global Health, 2020, p. 1) affected by female genital mutilation (FGM). This incident might lead them to be the victim of lifelong physical and psychological harm. This harm might be encountered if adequate knowledge of SRHR can be provided to them. To some extent, this has (Ghebreyesus & Kanem, 2018, p. 1) become the right issue for women and adolescences. Interestingly, structural determinants are (George et al., 2020) essential for SRHR knowledge of girls. Adolescent responsive SRHR programming is (Kabiru, 2019) being addressed since ICPD. These young people are (Biglia & Olivella-Quintana, 2014, p. 5) observed to participate more actively in those programs than others in the Catalonian context. Rural adolescents are (Phongluxa et al., 2020, p. 1) to be less informed on the Laos context. Eventually, girls might (Jewitt & Ryley, 2014) lag in terms of participation due to their menstrual process in the Kenyan context as the least support is hugely absent. Migrants (Calderón-Jaramillo et al., 2020), young (Wado et al., 2020) people growing up, and adolescents

(Mills, 2020) with disabilities like deafness in slum areas tend to be exposed to such more vulnerabilities.

This responsiveness is (Narasimhan et al., 2016, p. 684) relevant for combatting STDs epidemic adolescents. Nigerian and Indian context (Reddy & Sen, 2013, p. 29) mostly support this case. Unfortunately, in the Sub-Saharan context, the women and adolescents are (Carlsson-Lalloo et al., 2020, p. 1) twice as likely to be affected with HIV than other counterparts.

However, several barriers such as (Casebolt, 2020) negative attitudes of providers and society, lack of trained providers, assumptions and inadequate knowledge amongst providers, communication limitations, inaccessible facilities, lack of transportation, high costs of care, unnecessary referrals, and risk factors like being low-income or experiencing violence are still prevalent.

Guttmacher–Lancet Commission identified thirteen common linkages (Starrs, Ezeh, Barker, Basu, Bertrand, Blum, Coll-Seck, Grover, Laski, Roa, et al., 2018, p. 2647) exist between adolescent SRHR and SDGs target. However, the thematic areas do not remain the same from country to country. This right domain does (Bajracharya, 2020, p. 1) vary due to country-specific restrictive laws and policies and that frequent, especially to the developing country. For example, Iran has (Khalajabadi Farahani, 2020) not become able to contextualize SRHR on their premises.

However, for the case of adolescents, all the prospective thematic areas are not relevant proportionately. Despite UN acceptance, sensitivity and controversy risen from country-level variation are (Hadi, 2017, p. 26) responsible for this irrelevancy. Contextualized social and moral narratives are (Akwara & Idele, 2020) important herewith. Eventually, all donor organizations do (Seims, 2011) not share common values regarding SRHR. Controversies have (Das & Roy, 2015) remained active in most of the impactful, relevant public

forum itself. Eventually, social workers might (Essack et al., 2016) hold conservative views on SRHR. It is (Vongsavanh et al., 2020) not surprising that student and parent communication over SRHR issues is too low. A national SRHR plan can (Mahmood et al., 2020) be the solution herewith also. Despite all of these discrepancies, the particular need for SRHR for adolescence is (Hobcraft & Baker, 2006) acknowledged.

For having a better SRHR scenario for adolescence, five principles need to be upheld. They are (Engel, Paul, Chalasani, Gonsalves, Ross, Chandra-Mouli, Cole, de Carvalho Eriksson, Hayes, Philipose, et al., 2019, p. 541) equity, quality, accountability, multiculturality, and meaningful engagement. Youth initiatives can (Villa-Torres & Svanemyr, 2015, p. 54) be pivotal to better the scenario.

Five areas for action have been proposed to adopt for having more better SRHR scenario for adolescents. These areas for action include (Plesons et al., 2019) to mobilize support, raise funding, implement laws and policies, and manage the strategy to have better SRHR situations. Development works (Vu et al., 2017) are fruitful here. For example, integration of SRHR and HIV programs (Stackpool-Moore et al., 2017) goes well to counter both objectives simultaneously. Such integration can (Seims & Khadduri, 2012, p. 184) optimize using both governments' and donor organizations' scarce resources. However, health care professionals (Bylund et al., 2020) need to be considered seriously within SRHR programs, especially for adolescents. However, unfortunately, the national health plan ("Bookshelf," 2013, p. 363) does not specify statistics on adolescent SRHR strategies in the Pacific youth context.

Later from more significant activism points, SRHR advocates need (Newman et al., 2014) to participate in the population dynamics discourse to make SRHR more relevant. This participation should (Chandra-Mouli et al., 2020) address itself according to contextual boundaries where they reside.

Despite all the barriers, controversies, or sensitiveness, the SRHR situation is (Chandra-Mouli et al., 2019) better. The inclusion of SRHR in the medical insurance scheme is (Grover, 2013). In some countries, adolescents' state has (Liang et al., 2019) been worsened. Moreover, COVID 19 induced pandemic has (Lindberg et al., 2020) suspected to roll the wheel of success to the backward.

1.4 SRHR, ADOLESCENCE, AND BANGLADESH

One of the unique characteristics of this age group of adolescence is introducing their reproductive health system. However, the knowledge regarding SRHR among people is (Hashem, 2009) inferior among them. Eventually, these adolescents are (Ainul et al., 2017; Chaudhari, 1998; Huq et al., 2005) discouraged to discuss SRHR issues. This absence does not mean the quite absence of premarital sexual activities as 40 percent of urban males and 20 percent of rural males are (Hashem, 2009) found to be engaged with sexual activities. More eventually, some adolescent girls have (Islam & Smyth, 2016) been found to be in prostitution. Sexual health and access to services are (Stackpool-Moore et al., 2017) need adolescents and youth.

This situation has (Plesons et al., 2019; Germain et al., 2015; Sen, 2010; Girard, 2014) not been resolved fully even after the International Conference on Population and Development (ICPD), the Beijing Platform for Action, and lastly, inclusion into SDGs. The relevancy has. (Chandra-Mouli et al., 2019) not ended yet also. Though almost forty percent of parents are (Bhuiyan, 2014), found to support sex education directly but postmenopausal (Tanira et al., 2009) scenarios, Obstetric (Cowgill et al., 2015; Walz et al., 2003) fistula complexity and intimate (Parvin et al., 2018; Sanawar et al., 2019) partner violence is also frustrating. This lack of knowledge

leads people to trust in superstition, menstrual (Singh et al., 2012) complexity, and local (Rashid et al., 2011) ineffective treatments. Such textbook superstition (Adebiyi et al., 2002) is to consume Papaya during the pregnancy period. The situation (Paul et al., 2014) is hazardous if it is in a remote rural setting. The same is (Krishnamurthy, 2009) also valid for during disaster. The situation is hazardous in other countries like Ghana (Adanu et al., 2012).

The situation can be improved through intervention (Yasmin et al., 2014) regarding menstrual health issues and stronger (Santhya & Jejeebhoy, 2015) policy formulation. Reproductive health issues can (Rita & Sultana, n.d.) be resolved through CSR initiatives for the respective industries. Another example of interventions can (Reza-Paul et al., 2019) be Ashodaya Samithi of India.

As discussed, the current SRHR research context is limited to the frontier concepts, but the core research question is missing until now. In this regard, two fundamental core questions are the state of SRHR among these adolescents in terms of Health Literacy and Information, Adolescent Health, Pubertal Maturation for girls, Pubertal Maturation for boys, Body Comfort, and the heterogeneous determinants of the respective righteous of such practices. This state of practice and determinants of practice are correlated with the cost-benefit of a healthy SRHR practice. Lastly, we need to go for policy options to understand the pathways of righteous change from the current state of practice to the expected practice state.

Unfortunately, incorporating SRHR into the development stream is not the old issue as poverty or others are. It did emerge in Bangladesh implicitly as a part of the population control program. More labor than needed or large family sizes are observed to be one of the hindrances to the development. The population control program later shifted its paradigm, moving into an emphasis on a series of international

conventions, programs, and many more in the international context. Despite this sort of activism for the last 25 years, less meaningful change has been observed. However, the implicit mentioning of the SDGs might stimulate the change to some extent.

1.5 POLICY LANDSCAPE

Bangladesh's policy domain (Sida, 2008) referred to menstrual issues as included in the Essential Service Delivery (ESD) package stating available at the health clinics. This inclusion comes in the form of Within the health program, UPHCP II – Urban Primary Health Care Program, Support to RHSTEP, SRHR consortium, ICDDR, B – research institution, and other points. By 2030, Bangladesh has (National Strategy for Adolescent Health 2017-2030 Summary of Key Messages and Strategies, n.d.) set its goal to ensure a healthy and productive life in a socially secure and supportive environment. The period for this target has been set for 14 years ranging from 2017 to 2030. The principles have been based on human rights principal through highlighting the rights of adolescents. Four strategic directions mentioned here are Adolescent Sexual and Reproductive Health (SRH), Violence Against Adolescents, Adolescent Nutrition, and Mental Health of Adolescents. Under the Adolescent Sexual and Reproductive Health (ASRH) domain, this policy document has set four clear policies to adopt. These are (Ministry of Health and Family Welfare, 2016) enabling evidence-based advocacy, sexuality education promotion, capacity building, and robust system creation for data collection and analysis. Later a plan of action has (Sultana & Tareque, 2019) also been proposed herewith. Though no global parameter has not yet been set up, it is supposed to Bangladesh lag (Bangladesh Country Profile on Universal Access to Sexual and Reproductive Rights | Asian-Pacific Resource and Research Centre for Women (ARROW), n.d.) behind the global standard. Instead, to foster change, Bangladesh is formulating an MHM strategy paper.

Director General of family planning of Bangladesh has taken an initiative to upgrade one third MNCH centers to provide adolescent-friendly and reproductive health services and reducing adolescent pregnancies. Ministry of Women and Children affairs did not shift yet to the SRHR issues, at least from its already adopted or current ongoing development initiatives.

Under this policy circumstance, it has been clear that Bangladesh has aimed to generate evidence-based insights regarding ASRH. However, unfortunately, there does not exist any single study to explore the SRHR status of adolescence. This gap in the literature is prevalent from previous sections simultaneously. This gap fulfillment in terms of policy targets has become urgent, at least on a smaller scale. This study is targeting exactly this gap to fulfill.

2. OBJECTIVES AND METHODOLOGY

2.1 THE OBJECTIVE OF THE STUDY

The prime objective of this study is to explore SRHR practice and its determinants. This objective can be broken down into the following segments:

1. To explore the SRHR practice among adolescents,
2. To explore determinants of the right-based practice,
3. To explore the cost-benefit aspect of the current state and
4. To explore policy options as a way of positive interventions

2.2 RESEARCH QUESTIONS

The research questions of the study are closely related to the objective of the study. The objective of the study is self-explanatory in terms of explaining the research questions and those are explained in the following table:

Research objective	Research questions
SRHR PRACTICE	• To explore the state of literacy-related information among adolescence, • To explore the state of adolescent health among adolescence • To explore the state of pubertal maturation for girls among adolescence

Research objective	Research questions
	• To explore the state of pubertal maturation for boys among adolescence • To explore the state of body comfort among adolescence
Determinants of the righteous of practice	• To explore the determinants of literacy-related information state among adolescence, • To explore the determinants of adolescent health among adolescence • To explore the determinants of pubertal maturation for girls among adolescence • To explore the determinants of pubertal maturation for boys among adolescence • To explore the determinants of physical comfort among adolescence
Cost-benefit analysis	To understand the cost-benefit dynamics
Policy options	What should be the policy options?

Table 3: *Research Questions Breakdown*

2.3 HYPOTHESIS

This research is undertaken based on the following assumptions:

1. SRHR practice among the poor adolescents

2. SRHR practice can be explained through the state of SRHR knowledge, pubertal maturation status, and the state of physical comfort.

These two primary hypotheses are core to the analysis as the research objective, and research questions are formulated upon these three assumptions.

2.4 CONCEPTUAL FRAMEWORK

This research's conceptual framework is central to the concept of practice and the determinants of practice. The comprehensive definition of SRHR to adolescents identifies (Engel, Paul, Chalasani, Gonsalves, Ross, Chandra-Mouli, Cole, de Carvalho Eriksson, Hayes, & Philipose, 2019) adolescent-specific implications in general In 1998, The government of Bangladesh (Nahid Mukith Chowdhury & Moni, 2004) introduced the health and population sector program incorporating menstrual regulation as an essential service package. Despite them, a lack of knowledge regarding "what is normal" during the menstrual period (Chloe & Vora, 2018) is evident.

The current status of practice is getting better but has not been optimized until now. Moreover, the social, cultural, and religious restriction against menstruation and menstrual practice (Kaur et al., 2018) is immense. The menstrual facilities at school for girls are (Alam et al., 2017) too low.

The demand and supply of SRHR facilities among unmarried adolescents are mismatched for a long time in Bangladesh. This unmet demand is (van Reeuwijk & Nahar, 2013), creating a negative understanding of sexuality and wellbeing.

The existing research practices are issue-based, and any attempt to identify the determinants and cost-benefit analysis of both short-run or long run is missing. A complete approach is also missing, whether it is for adolescence or older or adult. The evidence of such insights has been reported earlier.

Global Early Adolescent Study commissioned at Johns Hopkins Bloomberg School of Public Health incorporation with World Health Organization has produced a set of conceptual frameworks to identify some issues addressed to explore the state of Adolescence SRHR. This study has adopted this protocol with some modifications. Along with this set of protocols, this study has modified the conceptual framework in the following manner:

Figure 5: *Practice and determinants (Conceptual framework)*

This set of practice determinants is relevant for determining the righteousness of practice as a whole and as the determinants of each practice segment. This modification has been done considering the sensitivity and also due to resource and time constraints.

2.5 RESEARCH METHODS AND PROCEDURES

This research follows a mixed method research containing both qualitative and quantitative research techniques. The qualitative techniques do include FGDs and KIIs. The

quantitative methods include sample survey, descriptive analysis, and inferential analysis from that sample survey.

The objective of quantitative methods is to produce measurement in terms of the research question and infer the generalized situation in terms of regression. The quantitative analysis does provide the possible cases for the explanation but does not explain itself. Thus, we need qualitative analysis in terms of FGDs and KIIs to have a cross-check with reality. That is the rationale for the inclusion of qualitative analysis.

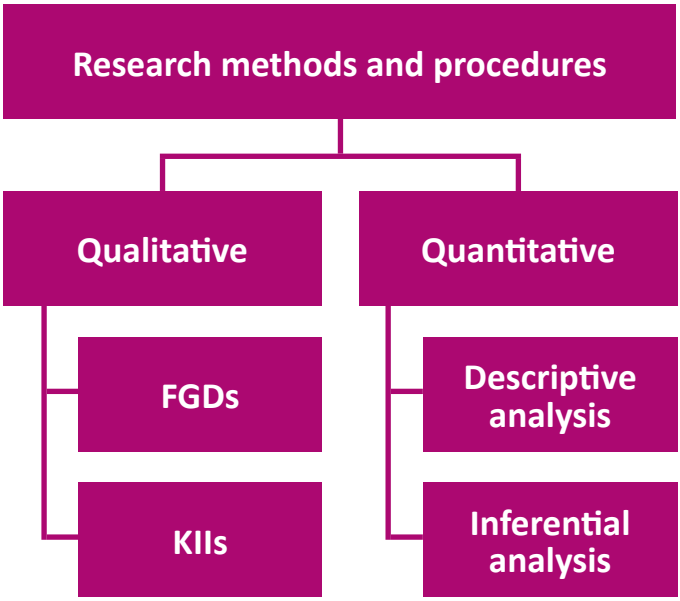


Figure 6: *Research Methods and Procedures*

2.6 METHODOLOGY

Research methods used to derive the answer to the research questions concerning undergone research assumptions are stated as below:

Research objective	Research questions	Methods imposition
SRHR practice	To explore the state of literacy and information among adolescence,	Descriptive analysis and FGDs
	To explore the state of adolescent health among adolescence	Descriptive analysis and FGDs
	To explore the state of pubertal maturation for girls among adolescence	Descriptive analysis and FGDs
	To explore the state of pubertal maturation for boys among adolescence	Descriptive analysis and FGDs
	To explore the state of body comfort among adolescence	Descriptive analysis and FGDs
Determinants of the righteous of practice	To explore the determinants of literacy and information state among adolescence,	Inferential analysis and FGDs
	To explore the determinants of adolescent health among adolescence	Inferential analysis and FGDs
	To explore the determinants of pubertal maturation for girls among adolescence	Inferential analysis and FGDs
	To explore the determinants of pubertal maturation for boys among adolescence	Inferential analysis and FGDs

Research objective	Research questions	Methods imposition
	To explore the determinants of body comfort among adolescence	Inferential analysis and FGDs
Cost-benefit analysis	To conduct a cost-benefit analysis for short-run	Secondary analysis
	To conduct a cost-benefit analysis for the long run	Secondary analysis
Policy options	What should be the policy options?	Secondary analysis, descriptive analysis, and inferential analysis

Table 4: *Methods over Research Questions*

2.7 POPULATION AND DATA COLLECTION METHOD

This study has confined itself to adolescents in educational institutions. Due to the unavailability of these students' data, the sampling technique has been run over Dhaka City corporations' total adolescent population.

By assuming a 5 percent margin of error, 95 percent confidence interval, and fifty percent response distribution, the required sample size becomes 384. This number has been determined in this way:

$$n = p(1-p)\left(\frac{Z}{E}\right)^2 = 0.5(1-0.5)\left(\frac{Z}{E}\right)^2 = 0.5(1-0.5)\left(\frac{1.96}{0.05}\right)^2 = 384.2\,.$$

This sample size can be distributed in the following manner proportionately.

Age Group	Both Sex	Male	Female	Sex Ratio
Early adolescence	184	90	87	103.7
Late adolescence	200	106	94	111.9
Total adolescence	384	196	181	107.8

Table 6: *Sampling Details*

The sampling Table presented above does provide the number of rationales for sample size selection. The population of early adolescence does belong to the age of a group of ten to fourteen. Moreover, this age group population does belong to secondary schooling. For more simplification, we can increase this number from 177 to 200 to ensure representativeness as well. Moreover, this age group belongs to the students ranged from class six to class ten. A total of forty samples can be attributed to each site sharing five samples to each class also.

The number of Qualitative operations in terms of other details is presented below:

SL. No.	Qualitative Operation Name	Numbers	Participants
1	FGDs	4	Early boy adolescence, late boy adolescence, early girl adolescence, and late girl Adolescence
2	KIIs	8	Parents and teachers

Table 7: *Number of Qualitative Operations*

Due to Covid-19, door-to-door data collection was not found as a feasible option at all. That is why we have adopted a different plan for data collection.

SL. No.	Method Type	Covid-19 adjusted tools	Previous tools	Deviation Rationale due to Covid-19
1	Sample Survey	Cobotoolbox	Cobotoolbox	Due to Covid-19 situations, the respondents filled form by themselves instead of asking and filling by the appointed enumerators.
2	FGDs	Google meet	Physical session	Due to Covid-19 situations, FGDs were conducted online through google meet platforms instead of physical session and recorded through Screen Recorder.
3	KIIs	Google meet	Physical session	Due to Covid-19 situations, KIIs were conducted online through google meet platforms instead of physical session and recorded through Screen Recorder.

Table 8: *Study Methods and Tools Detailing*

For the quantitative part, this study has adopted the Cobotoolbox to collect and checked data by calling the subject as the proxy of quality check. At least ten percent of data were checked through the data manager in this way also. Moreover, this ten percent has been utterly random by ensuring representativeness over institutions' underlying factors and day of data collection. A group of eight enumerators with one field manager has collected data from the field.

2.8 ETHICAL CONSIDERATION

The data collection protocol presented herewith has been designed in line with the WHO and GEAS guidelines. This mixed-method data has been collected through two different data collection protocols. The quantitative survey has been conducted first, followed by conducting a qualitative. This portion has assisted us in avoiding methodological overlapping to some extent. Beyond these two dichotomies, there does exist a standard set of ethics principles as a fundamental basis. This domain includes Respect, Beneficence, Justice, and Autonomy. Respect includes the ability to make their own decisions, unique and free to be themselves, value, and deserve respect and the right to receive complete information about the research impacting them or their community. Protection from physical, mental, and social harm, Minimal risks from participating in research, and the Benefits of Participating in research can be attributed to Beneficence. Justice does include proper research, performed according to the research plan, an equal distribution of risks and benefits, fair recruitment for research participation, and superior protection for vulnerable groups. To have the right to choose what is in their own best interest and freedom from outside influence in self-determination can be attributed to Justice. These four domains concerning their respective sub-domains would be upheld through the entire data collection process. These domains and the corresponding sub-domains have been adopted from the GEAS study.

2.8.1 QUANTITATIVE DATA COLLECTION PROTOCOL

The critical principles, as stated before, remain consistent for this section. Before approaching the survey form, written consent from the adolescents' parents has been collected through a google form.

The survey form has been sent directly to those whose parents have only provided the consent form's prior permission. The respective enumerator has thanked the guardian through a phone call, and that is also recorded. Proper training has been provided to the enumerators by using google meet.

2.8.2 QUALITATIVE DATA COLLECTION PROTOCOL

The fundamental principle for this part has remained the same as stated before. This portion has been performed only after the completion of the quantitative portion. This portion of the study does include both adolescents and the adults. The only difference to treat them is to take consent. For adult participants, the consent has been taken from themselves only. For adolescent participants, the consent has been taken from both their legal guardian and the participant him/herself simultaneously. This portion has been conducted through the principal investigator himself.

Beyond this three-core data collection protocol, GEAS and WHO guidelines were strictly followed if any point of controversy arises.

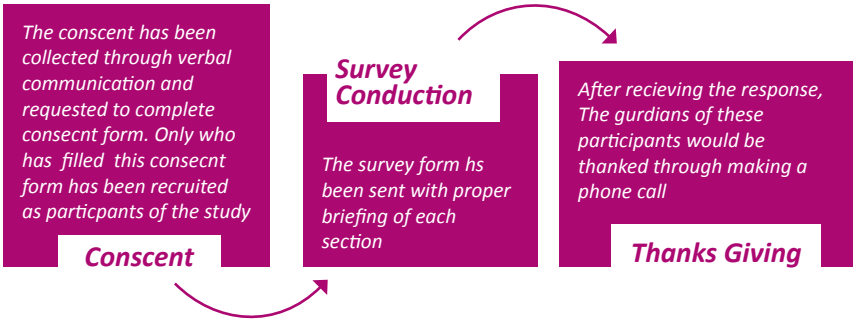


Figure 6: Data Collection Framework

2.8.3 SIGNIFICANCE OF THE STUDY

Sexual and reproductive health services included in MDGs and later also in SDGs (Lince-Deroche et al., 2016). Interventions can make the scenario improved (Amin et al., 2016). BALIKA could (Amin et al., 2016) be one of the examples of such interventions. Eventually, the educational interventions among (Wikström et al., 2018) the homeless people regarding SRHR knowledge works are significant. Sex education has (Reis et al., 2011) become a need due to its capability of making positive change. The situations have (Germain & Liljestrand, 2009) improved since the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women in 1995. But it has not optimized till now. All these have constructed the urgency for understanding the practice dynamics.

If we summarize the previous sections of this report, several axioms become evident. These axioms are the need for the interventions to make the situation better, and very few surveillance statistics are available denoting SRHR. If the survival statistics are not available, we can not design the intervention pathways. This study is not necessarily claiming to reveal the entire statistical reality. It might be the first step to know SRHR as a surveillance report among the urban adolescents. This gap-fulfilling is the significance of this study.

Once again, under the contextual scenario of this study, this is significant as it does have some more strong contributory points. They are to make the ongoing development projects informed about the current state, the determinants' role, and the policy aspect. It is also adding value to the SDGs stream as it is somewhat included in SDGs.

The scoping up factors for this research include and exclude issues, scaling up to the national scale, including youth and adolescent, and covering persons beyond the school.

3. DATA ANALYSIS AND FINDINGS

3.1 DEMOGRAPHIC DETAILS

There are two states of adolescents- early adolescents and late adolescents. According to the previous part's promise, this study has collected on two walks of this stage. It includes the adolescents studying from class six to bachelor 2nd year from a handful number of organizations. I have attempted to keep the ratio as stated as needs. However, due to reality related to lockdown, this ratio cannot be maintained throughout the study period. However, the total number of respondents has been maintained strictly, and that is at least 400.

Every cluster of the study level contains adolescents of at least 31 and at best 40 by frequency. Moreover, the average for those is 46 by each cluster. The study level of Bachelor 1st year is 60, and that is highest by cluster, covering almost 14.6 percent of the entire respondents. The students of class ten did respond less, which is 31 by number covering 7.5 percent of the entire study.

According to the promise of the adolescents, the age needs to range from twelve to nineteen. This study has been stuck to this number, and if any responses beyond this age limit are recorded accidentally, it has been skipped to this entire analysis.

The respondents aged 19 have responded most, and that is 100 by number covering 24.33 percent of the respondents' total number. On the contrary, the least responding aged group was sixteen, and the number of respondents was 36, covering 8.76 percent of the entire respondent group. The average of this number is 51 by age group.

SL. No.	Variable Name	Value Details							
1	Age	10.70% aged at 12	10.90% aged at 13	11.70% aged at 14	10.50% aged at 15	8.80% aged at 16	10% aged at 17	13.10% aged at 18	24.30% aged at 19
2	Gender	53.1% male				46.9% female			
3	Relegion	93.15% Islam		5.62% Hinduism		0.98% Chirsitiamity		0.24% Others	
4	Parents' Income	3.91% earning 0 – 10000 BDT	3.67% earning 10000 – 20000 BDT	11.74% earning 20000 – 30000 BDT	30.07% earning 30000 – 40000 BDT	25.43 earning 40000 – 50000 BDT		25.18% earning More than 50000 BDT	

Table 9: Demographic Details

The gender distribution is somewhat symmetric as this study was aimed to make representativeness in terms of gender has attempted also achieved.

Forty-seven percent of the respondents are female, covering 192 in total. The remaining 53 percent of the respondents are male, covering 217 by number. No single individual with the third gender has been reported/included in the study.

Mostly reported religion of the respondents is Islam, which is also the major religion practiced in Bangladesh. This number is 381, and that covers almost 93.1 percent of the entire respondents. The second most practiced religion is Hinduism, 23 by number covering just 5.6 percent of the respondents' total number. Mentionable that only one respondent said that his religion as "Other" only.

The family income for most respondents is solvent, compared to the country average. Few respondents belong to poor income earning family, which is by number 16, covering only

3.9 percent of all respondents. Most of them come from a family background with a monthly income ranging from Taka thirty thousand to forty thousand. This number is 123, covering 30 percent of the entire respondents. 92.4 percent of the respondents come from a family of a monthly income of more than twenty thousand Taka. This number is 378, and that represents the family background of the majority of the respondents.

3.2 THE STATE OF LITERACY AND INFORMATION AMONG ADOLESCENTS

This study has attempted to understand the state of knowledge based on several questions. These include their state of knowledge, sources of knowledge, their perception over several issues, including menstruation and puberty, and their state of discussion on those issues.

Eighty percent of the respondents do state that they have a necessary acquaintance with the sexually transmitted disease. This is 328 out of a total of 410 respondents. Unfortunately, 15.6 percent did not have heard about the sexually transmitted disease, and it only 64 of the total respondents. Unfortunately, the remaining 18 respondents did not answer, covering 4.4 percent of the entire respondents.

The situation is worse regarding the belief towards any way to prevent these sexually transmitted diseases. Only 283 respondents covering 69 percent, believe that there exists any way to prevent these diseases. Sixty-four respondents covering 15.6 percent of the total respondents, believe that there does exist no way to prevent these diseases. Sixty-three respondents covering 15.4 percent of the total, did refuse to answer this question. If anyone is acquainted with the sexually transmitted disease, they generally do not believe that these diseases can be prevented.

Comparatively, fewer adolescents do know any contraceptive method. Only 245 respondents covering 60 percent of the total, know this. One hundred thirty respondents covering 31.9 percent of the total, did not know and the remaining 33 respondents (8.1 percent), refuse to answer this question. This scenario is more frustrating as those who believe in preventing those diseases, do not necessarily know the prevention method.

Just 33.8 percent of the entire respondents did ever talk with anyone regarding contraception. If anyone knows the contraceptive methods, does not necessarily talk about those at all. More surprisingly, one in two contraceptive knowledgeable persons is supposed to talk about the contraception method. 66.2 percent did not talk or discuss at all.

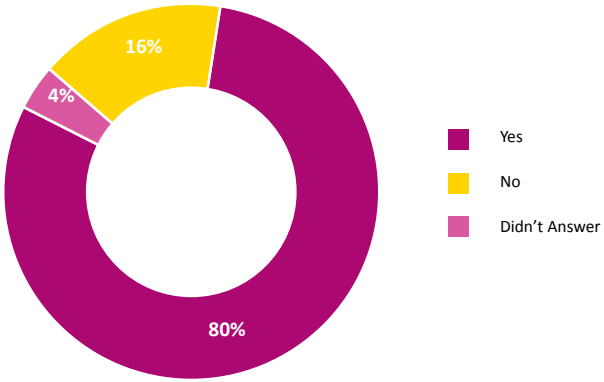
However, beyond this statistical reality, due to textbook incorporation of sexually transmitted diseases and mass campaign on mainstream media, it is quite frequent to gather some knowledge autonomously even if they can not figure out the reality. Most of them know this does come from friends and cousins, covering 25 percent of all adolescents. Moreover, the most frequent one is the educational institutes. However, these educational institutes have been yet the far way to teach them in the classroom. Unfortunately, only 15 respondents did get knowledge from their parents, which is just 3.8 percent of all respondents. However, if they were the majority, exact knowledge transformation would be relatively more effortless.

76.66 percent of the entire respondents covering 312 individual respondents are informed of the menstruation. The remaining 23.3 percent are not informed of this at all. This number covers 95 respondents only.

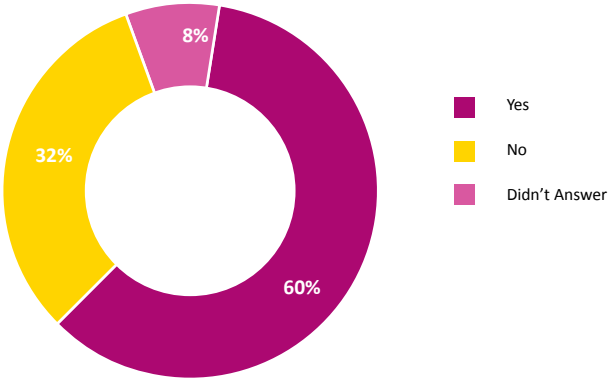
To those who are not adequately informed about menstruation, it does not seem curse to them. And this quite optimistic. Only 18.8 percent of the respondents have perceived it as is to be a curse. The remaining portions of

the respondents have not taken it as a curse. Unfortunately, more adolescents have perceived that girls are dirty during their menstruation. This number is 77, covering 24.8 percent of the entire study population. The remaining 75.2 percent have perceived this otherwise also. A similar portion of the respondents has agreed to buy the menstrual product for their sister or close cousin if needs. 71.9 percent did agree to this, and the rest did not at all. More optimistically, only 9 percent pointed out buying menstruation products is a waste of money. The remaining 91 percent have adopted this one otherwise. Unfortunately, more adolescents have opined that girls should not go outside during their menstruation. Hopefully, they are not the majority at all though their share was 17.8 percent. 19.7 percent of the adolescents are not sure whether they would go or not at all. Fortunately remaining 62.5 percent have perceived that girls should go outside during their ministration. Eleven percent of the adolescents did assume that girls should hide their menstruation from the family members, and 14.52 percent is confused. Fortunately remaining 74.5 percent perceives that girls should not hide this at all from their family members.

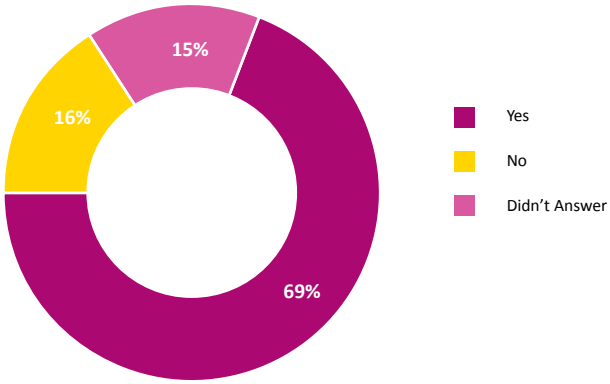
Have you ever heard about sexually transmitted diseases?



Do you know about any contraceptive method?



Do you believe whether there exists anyway to prevent these diseases?



Have you ever talked with anyone regarding contraception?

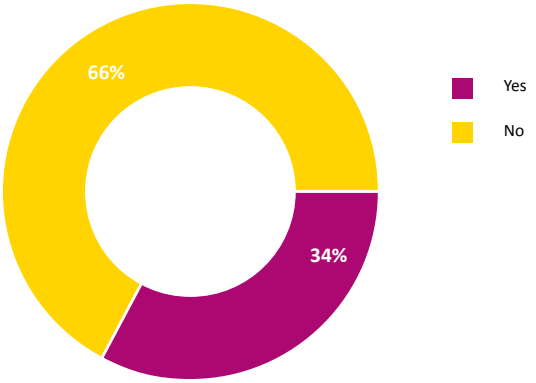
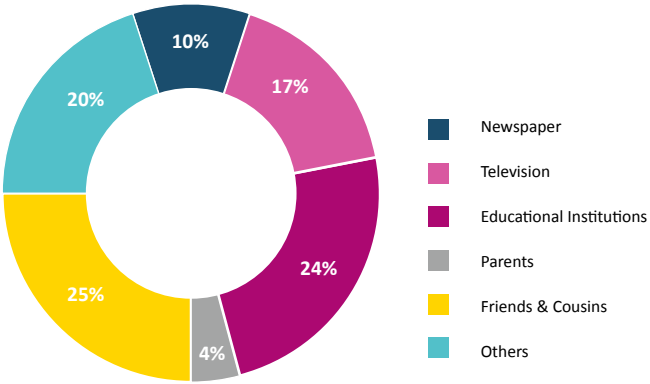
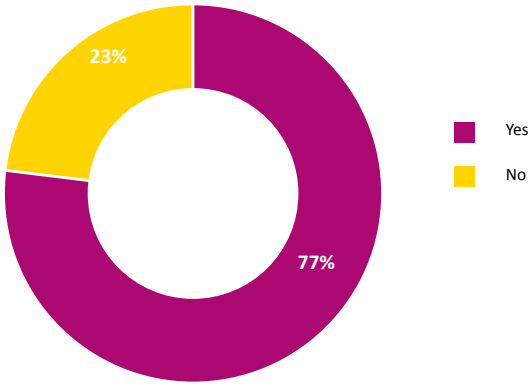


Figure 7: The state of Literacy and Information among adolescence (Part 1)

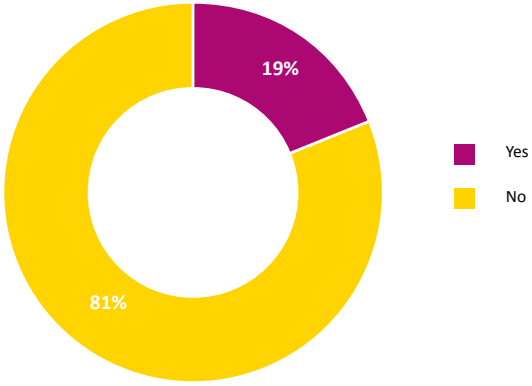
What is the source of your knowledge regarding contraception?



Are you informed about the menstruation process?



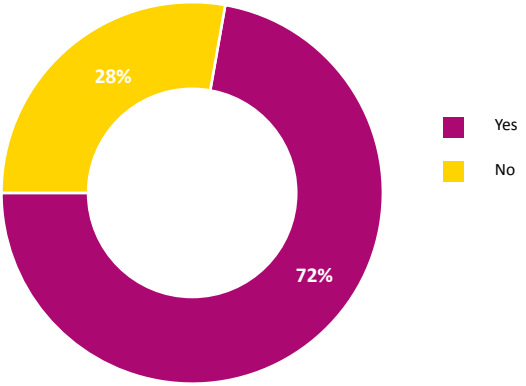
Do you think menstruation is a curse to the girls?



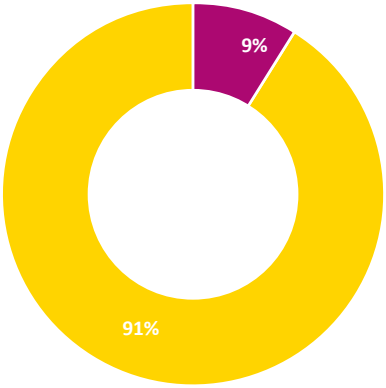
Do you believe girls are dirty during their menstruation?

Figure 8: The state of Literacy and Information among adolescence (Part 2)

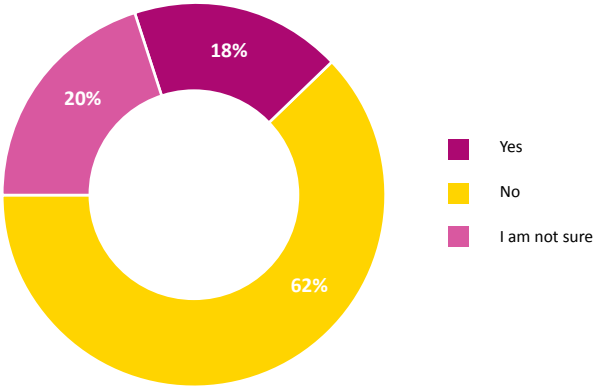
Would you buy a menstrual product for your sister or close cousin?



Do you think money is wested if it is used for buying the menstrual product?



Do you believe girls should not go outside during the menstruation period?



Do you think girls should hide menstruation from the family member?

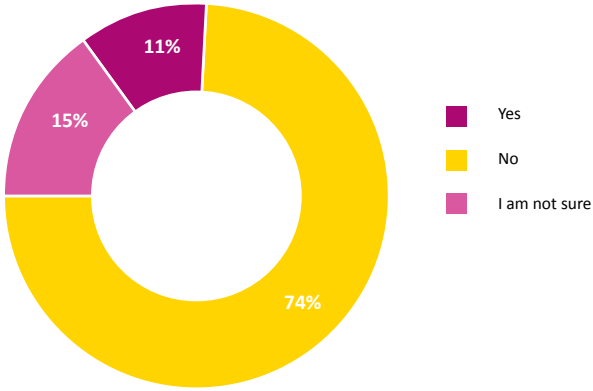
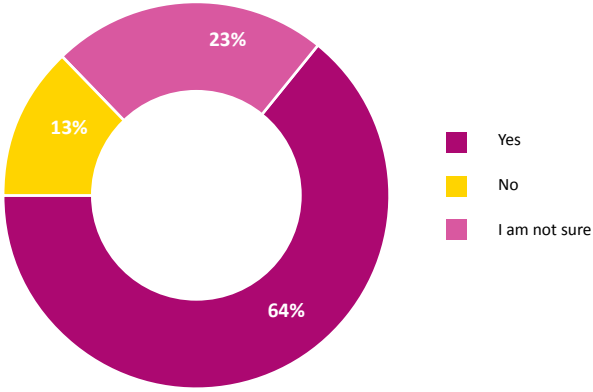


Figure 9: The state of Literacy and Information among adolescence (Part 3)

Do you fell necessity of family planning?



Does anyone discuss family planning with you frankly?

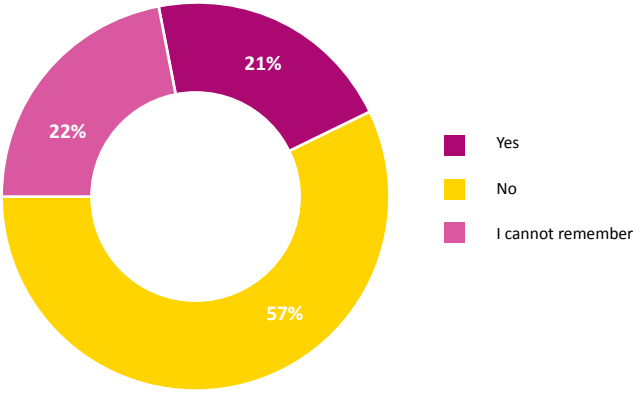


Figure 9: The state of Literacy and Information among adolescence (Part 4)

The perception of the necessity of family planning is another essential issue to be acquainted. Only 63.90 percent did acknowledge this, and felt it is necessary. The remaining 12.93 percent did not feel necessary at all, and 23.17 percent is confused on this issue. Just only 20.78 percent of adolescents have discussed the family planning issue. 20.78 percent reported that none has discussed this with them, and 21.76 percent cannot remember this at all.

3.3 THE STATE OF ADOLESCENT HEALTH

Most of the adolescents comprising 80.88 percent did acknowledge that they are grown up physically and mentally. 45.59 percent are bullied for their height, and 46.31 percent are bullied for their weight. Moreover, they have reacted to the point of being bullied with some minor exceptions.

Response	Respondents oponiion whether growing up physically and mentally or not Percent	Respondent reaction in the case being bullied due to height Percent	Response	Respondents opinion toward whether being bullied or not due to current weight Percent	Respondent reaction in the case being bullied due to height Percent	Respondent reaction while the case being bullied due to height Percent
Yes	80.88	43.7	Yes	45.59	46.31	39.46
No	9.07	38.52	No	45.59	40.15	50.98
I am not sure	10.05	17.7	I cannot remember	8.82	13.55	9.56
Total	**100**	**100**	**Total**	**100**	**100**	**100**

Table 9: The state of adolescent health among adolescence

This situation is interesting because one in two adolescents are bullied and have reacted to being bullied with some exceptions roughly. This incident of being bullied has been an epidemic to some point, as this statistics pointed out.

3.4 THE STATE OF PUBERTAL MATURATION FOR GIRLS DURING ADOLESCENCE

65.61 percent report that they feel that their body is being changed, but unfortunately, only 36.36 percent track the change of body. 31.91 percent wish to keep this change secret also.

Response	Whether to feel body change or not Percent	Wheather to track body change or not. Percent	Whether to have Willingness to keep body change secret or not. Percent
Yes	65.61	36.36	31.91
No	17.99	39.04	48.4
I am not sure	16.4	24.6	19.68
Total	**100**	**100**	**100**

Table 10: The state of pubertal maturation for girls among adolescence (Part 1)

This scenario can be interpreted that two in one is tracking their body change, and they wish to keep it secret, though we know that the change of body during adolescence is quite natural and anything that is natural is not an issue to hide at all.

Just half of the responding adolescents report that they miss their educational institutes (schools and colleges, or universities) due to health abnormalities. Moreover, just half of them (responding adolescence) has talked about such change of body. This scenario is quite frustrating one.

Response	Whether to miss schools/ colleges/ universities due to health condition abnormalities or not Percent	Whether to talk about body change with anyone or not Percent
Yes	34.39	49.73
No	50.26	37.43
I cannot remember	15.34	12.83
Total	**100**	**100**

Table 11: The state of pubertal maturation for girls among adolescence (Part 2)

3.5 THE STATE OF PUBERTAL MATURATION FOR BOYS AMONG ADOLESCENCE

72.22 percent of the male adolescents' report that their voice is being changed. This percentage is 79.63 for the case of beard or mustaches growing.

This growth is not welcoming for them at all. One of two reports they are embarrassed due to this sort of body change.

Response	Whether to feel voice change or not Percent	Whether to feel beard ,or mustaches growing or not Percent	Whether to feel embarrassed due to this change or not Percent
Yes	72.22	79.63	35.65
No	20.83	14.81	57.41
I am not sure	6.94	5.56	6.94
Total	**100**	**100**	**100**

Table 12: The state of Pubertal Maturation for boys among adolescence

3.6 THE STATE OF BODY COMFORT AMONG ADOLESCENCE

The state of body comfort among adolescence is relatively low. Only 59.46 percent of the entire adolescence are satisfied with their respective height. Moreover, this percentage is just 40.79 for the cases of weight. They are not happy with their

Response	Whether to be satisfied with current height or not Percent	Whether to be satisfied with current weight or not Percent	To assume childhood better than now or not Percent	Whether to feel embarrassed due to body change or not Percent	Whether to feel embarrassed during body change or not Percent
Yes	59.46	40.79	54.41	30.86	33.33
No	28.99	46.44	27.45	54.81	52.94
I am not sure	11.55	12.78	18.14	14.32	13.73
Total	**100**	**100**	**100**	**100**	**100**

Table 12: The state of Body Comfort among adolescence

current state compared with childhood. Only 54.41 percent is perceiving they are now better than that of their childhood. This scenario is almost homogenous if we count their feeling toward their body change. Only 54.81 percent of adolescents are not embarrassed due to their body change. The remaining portions of the adolescents are somewhat embarrassed. This scenario is the same by portion is it is expanded to "during body change scenario". This percentage then becomes 52.94 percent.

3.7 DETERMINANTS OF THE PROPER WAY OF PRACTICE

The righteous of the practice can come out in literacy and Information state, Adolescent Health among adolescence, Pubertal Maturation for girls, Pubertal Maturation for boys, Body Comfort among adolescents. In the hypothesis section, it was hypothesized that the practice's righteousness could be explored as a form of the state of other variables. However, unfortunately, none of the variables is statistically significant to be the potential determinant. Here the statistically significant

Dependent Variable	Independent Variable clusters			Remarks
Literacy and Information state	Adolescent Health among	Pubertal Maturation	Body Comfort	
Adolescent Health	Literacy and Information state	Pubertal Maturation	Body Comfort	Dependent Variable Independent Variable clusters Remarks
Pubertal Maturation	Literacy and Information state	Adolescent Health among	Body Comfort	
Body Comfort	Literacy and Information state	Adolescent Health among	Pubertal Maturation	

Table 12: The inferential analysis summary

does denote at least 90 percent confidence interval, and very low R squared value. This report does not elaborate to include all those regression details.

This table does imply that one component of SRHR can not explain any of the other components. Moreover, this is true, at least for the components discussed within the scope of this study.

Unfortunately, none of them does prove itself to be a potential to be determinants. Statistically, R squared has become too small, and none of them did qualify within a 10 percent confidence interval. This non-qualifying aspect has another policy level significance. If we wish that we would emphasize a single factor aiming more impactful to others, it must not be valid. So this no-qualifying aspect does emphasis adopting all possible aspects in a single frame. Otherwise, the entire betterment must not be the feasible case at all.

3.8 COST BENEFIT ANALYSIS

The cost-benefit aspect of SRHR does somewhat go beyond the number though it might seem unusual. This analysis has two layers from two points of view. The first one is the long run and the short run. Then there are the micro and macro-level. This section has been determined through the qualitative approach.

In the short run, the standard community-specific SRHR knowledge cost is to spread the knowledge and buy the SRHR products for the eligible adolescents. The short-run effect is not to be engaged with any of the non-righteous practices. One of the guardians states that:

"My son knows what the human body is. He must not involve in any non-righteous practice. My belief is intake till now."

	Micro Perspective	Macro Perspective
Short Run Cost	To buy SRHR products for the eligible ones.	To fund programs for awareness building regarding SRHR
Short Run Benefit	Not to be engaged with non-righteous practice at all	A society with less gender violence and less non-righteous practice
Long-Run Cost	Continue to buy SRHR products for the eligible ones.	To continue funding to the programs for awareness building regarding SRHR
Long Run Benefit	Continue not to be engaged with non-righteous practice at all at the individual level	Mainstreamed SRHR practice

Table 14: Cost-Benefit Analysis

Moreover, this is a micro-level issue. To funding for this consciousness rising from the behavioral communication program is the macro-level aspect of cost.

The long-run prospective impact of a standard SRHR practice is to mainstream righteous SRHR practice. This macro level scenario aims to ensure a situation so that none can get engaged with the non-righteous practice. To continue to buy SRHR goods as required and to continue to fund SRHR programs are the cost side in the long run.

4. DISCUSSION

4.1 KEY FINDINGS

4.1.1 STATE OF KNOWLEDGE:

The family planning issue is still a taboo within the family environment. Even if the family planning issue comes in the form of what family size should be or when to rise this size, taboo's proposition remains relevant. Just 21 percent of adolescents discussed family planning issues frankly with family members or others. The working methods of family planning are the contraceptive methods. When the broader agenda of family planning is found to be missing, the knowledge regarding those contraceptives is seemingly absent. Just twenty-five percent were found to know those contraceptive methods from their friends and cousins. The friend of an adolescent is no wonder of being another adolescent. Moreover, the same analogy is appropriate for the cousin. When an adolescent is gaining knowledge from another one, and there is no guarantee that the other one does have proper knowledge, the possibility of spreading misinformation must rise. So we should ensure that they are learning from the trustable sources. The adolescents can discuss among themselves, but this discussion should not be the sole source of information.

This sort of the existence of binary knowledge did not come through the discussion among them at all. They might be the product of different campaigns. The adolescence knowing the contraceptive methods, have found not to discuss those among themselves at all. Just only one in three knowing those methods is found to discuss the contraceptive methods. More unfortunately, the contraceptive methods campaign through different family planning organizations is in operation. These

campaigns did not break the chain of the taboo. This reality leads them later to be involved with sexual malpractice, and it would not be a wonder if anyone did go far from family planning due to this taboo(s). For example, almost 64 percent have already perceived family planning as unnecessary. Lastly, till now, almost 40 percent adolescents are unaware.

The situation is a bit well for the case of menstruation. However, that is not optimized also. Eventually, all are not informed about menstruation at all. Twenty-five percent were kept left out. Sixty-three percent acknowledge that girls might go outside during their menstruation. The remaining thirty-seven percent consisted of another portion of respondents who claim girls to be dirty during their menstruation.

Moreover, they are roughly one-fourth of the total respondents. Eventually, they do not perceive menstruation as general. Seventy-five percent did think that the girls should hide their menstruation from boys. Eventually, all are not ready to buy the menstruation product, even if it is for their sisters or any close cousin. Twenty-eight percent would not go to buy. Some adolescents perceived menstruation as a curse, and spending money for this is just a waste of money. This group is comparatively smaller though they exist.

So adolescents do not have proper knowledge about their body functioning concerning sexuality/reproductive issues. We can not expect from them they all would be informed of the sexually transmitted disease at all. However, fortunately, 80 percent are informed, and this is quite optimistic. This acquaintance does mean to know the binary existence of the sexually transmitted disease. A detailed knowledge among all of these 80 percent is merely missing. Eventually, all of them do not presume that this can be prevented. Just 69 percent assume that these diseases can be prevented or controlled.

SL	Thematic areas	Indicators details
1	State of Knowledge	Only 80 percent of adolescents are acquainted with sexually transmitted diseases.
		Just 69.02 percent did perceive that there might be any way to prevent that sexually transmitted disease
		60.05 percent are aware of the contraceptive methods
		33.82 percent have talked about the contraceptive methods
		One in four did gain knowledge regarding contraceptive methods from their friends and cousins
		Just 75 percent of the adolescents are informed of the menstruation process roughly
		Almost 19 percent has perceived menstruation as a curse for girls
		Roughly one-fourth of adolescents perceived girls as dirty during their menstruation
		Only 72 percent of adolescents are agreed to buy menstrual products for their sisters or close cousin if necessary
		Just nine percent has perceived that spending money on menstruation goods a waste of money
		Just 63 percent did perceive girls can go outside during their menstruation
		Just 75 percent of adolescents perceive that girls should hide menstruation from the boys
		63.90 percent of adolescents have taken family planning as necessary
		Just 21 percent of adolescents discussed family planning issue frankly

SL	Thematic areas	Indicators details
2	State of Adolescents Health	80.88 percent of adolescents did feel that they are growing physically and mentally
		Just 50.98 percent of adolescents have remained not-bullied due to their current height
		43.7 percent reacts if they are bullied due to their height
		45.59 percent of adolescents are bullied due to their current weight
		46.31 percent of adolescents react if they are bullied due to their current weight
3	Pubertal Maturation (Girls	65.61 percent of adolescents perceive that the body is being changed
		Just 36.36 percent did track their body change
		31.91 percent of adolescents' girls are willing to keep their body change secret
4	Pubertal Maturation (Boys)	57.41 percent of the adolescents are not ashamed of their bread or mustaches
5	The State Of Body Comfort	59.46 percent of adolescents are satisfied with their current height
		40.79 percent of adolescents are satisfied with their current weight
		54.41 percent of adolescents perceive their childhood is better than now as they are.
		54.81 percent of adolescents are embarrassed due to their body change
		52.94 percent of adolescents are not embarrassed during their body change

SL	Thematic areas	Indicators details
6	Empowerment Issues	64.22 percent of adolescents can move freely
		62. 21 percent of adolescents feel free to express their opinion
		55.67 percent of adolescents can attend after school, college, or universities activities independently
		40.29 percent does perceive that they will be able to choose their partners shortly
		44.85 percent of adolescents do believe that they will be able to decide independently regarding when to marry
		48.28 percent of adolescents can decide to meet their friends independently or freely
		69.53 percent of adolescents can independently decide to attend religious activities like praying.

4.1.2 STATE OF ADOLESCENTS HEALTH

Adolescence is the bridge between childhood and adulthood. Thus, the psychological change is evident to a greater extent. It is quite common to feel that change. However, all of them is not feeling this change. Almost 19 percent did not acknowledge this at all.

Furthermore, this change does not happen at the same time or at same. So, this not simultaneously happening did lead them to bully or to be bullied. The most two visible changes

irrespective of gender is height and weight. Almost one in two are being bullied, and of the bullied, one in two reacts. It is quite unfortunate. The change is evident for every adolescent. As they do not know the change is universal to all of them, they find it interesting. It might not be surprising that any adolescent currently bulling due to height later at any point of time of his adolescent period.

4.1.3 PUBERTAL MATURATION

Pubertal maturation is one of the unique characteristics of this period. Unfortunately, the adolescents are not found to enjoy that somewhat to be annoyed with this one. The nature of the pubertal maturation is gender-dependent. It comes in terms of starting the menstruation process for the girls. Moreover, this experience is not well for them at all. One in three is willing to keep the body change secret, including the start of menstruation.

Furthermore, they do not track their body change. Just one in three does this. More irony is that two in three acknowledges this change. The adolescents are acknowledging the change, but not keeping track of this change. The most visible change due to pubertal maturation is their bread or mustaches. Moreover, it is quite natural where there does not exist anything to hide from or be ashamed of. Nevertheless, almost two of them are being ashamed.

4.1.4 THE STATE OF BODY COMFORT

The pubertal maturation and its consequences were supposed to give them a sense of satisfaction as they have grown up. However, the scenario is quite different. Almost half of them are not satisfied due to their current state of height and weight. Eventually, this is embarrassing for them due to the change and during the change as well, at least for almost half of them. The irony is that what is thought to make them proud is making them embarrassed also. This feeling leads them to think their childhood was better, at least for half of the case.

4.1.5 EMPOWERMENT ISSUES

Empowerment is essential for the adolescence as it provides them a sense of meaningful growth. However, they are not empowered fully, instead they are empowered to some extent. They enjoy almost no independence in deciding whom to marry, when to marry and when to meet their friends. They are supposed to decide this, at least according to the guidance of the parents. To some extent, parents might decide according to their own way for these adolescents regarding when to marry and whom to marry. They seem very interested in making busy these adolescences study instead of meeting with their friends. The adolescence enjoys more freedom in terms of free movement, expressing opinions, and praying. The parents seem a bit indifferent to control this sort of thing at all.

All these things have made the experience of adolescence as a nightmare. Interestingly, to be a nightmare is found to be expected from the societal point of view. The scenario can be quite different as that is for most of the developed countries. It could be not a nightmare rather a period for a feeling period.

4.2 DETERMINANTS:

From the previous section, none of the components can explain any other remaining components. This argument does provide an emphasis on the holistic approach for combatting SRHR practice. The current or the upcoming SRHR programs need to address all the relevant issues of SRHR to address either as a whole or individually within the project. If we miss one or more than one component, we cannot expect that the remaining components' change would change the left-out component.

4.3 LIMITATION OF THE STUDY

This study does capture the scenario of the adolescents with mid-level income and urban background. This study has not captured the rural-urban representation, religious heterogeneity, income group variety, and geographic variety also. This study has chosen almost 50 variables to study. The situation can be somewhat different if more other variables are incorporated.

4.4 SCOPING UP OPTIONS

This study can be scoped up if the number of variables is increased. This study would become more comprehensive if any other new initiative with rural-urban representation, religious heterogeneity, income group variety, and other relevant varieties can be captured within the sampling framework.

5. CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

Adolescence is a bridge between childhood to adulthood. This transition for every single person is very crucial. Some statistics kept under the broader line of state of the conditions of SRHR practice might seem optimistic. Nevertheless, unfortunately, we could not cover every single adolescent. The statistics presented in this report might seem very optimistic, but some adolescents could not be taken. The situation is worse for rural adolescents or the adolescents being brought up amid social or religious orthodoxy. This research has been conducted among a target group of adolescents who belong to the privileged parts of the society. It is very surprising that they still believe that menstruation is a curse or the girls are dirty during their menstruation. If the privileged portion are in such condition, the other counterparts could be in darker reality.

5.2 RECOMMENDATIONS

5.2.1 POLICY

This study recommends strictly to subsidize SRHR goods at the policy level and teach SRHR issues in the institutions through incorporating SRHR knowledge into the curriculum. If the SRHR goods can be subsidized, more adolescents would consume these goods. Most of the adolescents are found to express a positive attitude towards the standard SRHR practices. If the prices are lowered, more access is possible. Things do not end herewith. Even if all are knowledgeable, but the prices are not

subsidized, that knowledge will do no good to them as they would still be incapable of buying those products. A rising level of consumption is supposed to improve the current state of ASRHR also. The economic stimulation is also a supporting case/factor.

To teach SRHR at the institution level is another crucial aspect. If it can be taught at the institution level, we can hope for a more homogenous knowledge status among adolescents. There are two options, to teach them at their homes and to teach them at institutions. The first option might work for the girls, but it does not guarantee that this teaching would come without any superstition or malpractice. This possible consequence can be avoided if that is taught at the institution level. However, it needs authorization in terms of adding it into the curriculum. The religious orthodoxy or existing social dogma might put an embargo over this one without being included in the textbook. If the inclusion in the textbook goes alone, the results might end with nothing. Robust monitoring, whether they are being taught or not, should be conducted. Only then can we expect a better situation.

Lastly, it is also essential to incorporate SRHR issues into the policy documentation. Already the Government of Bangladesh is on its way to formulating an MHM strategy paper. However, the holistic approach is missing till now. The policy documentation would assist us in going forward with this issue also. The holistic approach needs all of the components to catch within a single framework. It would help us ensure that no SRHR components are left untouched as we cannot expect that the change in one component would trigger the change in the other components.

5.2.2 INTERVENTIONS

Organizations like Share-Net Bangladesh, BRAC, and some more are implementing development projects aiming at adolescents SRHR. However, the area coverage of both

Policy	• SRHR goods must be subsidized • SRHR issues are to be taught in the institutions lively • SRHR issues are to be incorporated in the broader policy documentation.
Interventions	The more behavioural change communication program
Research	A more comprehensive study incorporating all the varieties such as demography, rural-urban setting, religion, and others in the sampling framework on the larger scale

Table 15: Recommendations

thematic and geographical point of view is relatively low. More development interventions aiming at ASRHR are also needed. Instead, SRHR is also a cross-cutting development agenda. A better situation can be ensured through this. Also, as a success from such approach is also well documented. The example of the BALIKA project is also relevant here. This study also suggests that it needs to be holistic. Emphasizing any thematic area under SRHR does have little influence over other thematic areas also.

5.2.3 RESEARCH

Lastly, very little empirical research on this issue of the perspective of Bangladesh is available. Unfortunately, this hinders drawing the exact pathways for suitable development intervention. Therefore, more evidence-based research is an emergency need. The donor organizations dealing with research must come forward with a funding scheme for this as well. These studies should come forward with factors based on religious, gender, and geo-graphic diversity.

ANNEXES

QUANTATIVE CHECKLIST

Part 1: General Information		
Sl.	**Questions**	**Response**
1.1	What is your Name?	Open-Ended
1.2	In which educational institutions are you studying?	Open-Ended
1.3	At which level are you studying now?	1. Class Six 2. Class Seven 3. Class Eight 4. Class Nine 5. Class Ten 6. HSC 1st Year 7. HSC 2nd Year 8. Bachelor 1st Year 9. Bachelor 2nd Year
1.4	What is your current age?	Open-Ended
1.5	Describe your gender	a. Male b. Female
1.6	Name your religion	Open-Ended
1.7	What is your parent's monthly income?	Open-Ended
1.8	How many family members do you live together?	Open-Ended

Part 2: Literacy and Information		
Sl.	**Questions**	**Response**
2.1	Have you ever heard about sexually transmitted diseases?	a. Yes b. No
2.2	Do you believe there does anyway exist to prevent these diseases?	a. Yes b. No
2.3	Select the right answer (you can select more than one)	a. The sexually transmitted disease can transmit through water, air, and any other substances b. You might get affected with sexually transmitted diseases if you come with a contract of the affected one c. No medication is available for any of the sexually transmitted disease d. None of the above
2.4	Do you know any contraceptive method?	a. Yes b. No
2.5	Have you talked with anyone regarding contraception?	a. Yes b. No
2.6	What is the source of your knowledge regarding contraception?	Open-Ended
2.7	Are you informed about the menstruation process?	a. Yes b. No
2.8	Do you believe menstruation is a curse to girls?	a. Yes b. No
2.9	Do you believe girls are dirty during their menstruation?	a. Yes b. No

Part 2: Literacy and Information		
Sl.	**Questions**	**Response**
2.10	Would you buy a menstrual product for your sister or close cousin?	a. Yes b. No
2.11	Do you think money is wasted if it is used for buying the menstrual product?	a. Yes b. No
2.12	Do you believe girls should not go outside during the menstruation period?	a. Yes b. No c. I am not sure
2.13	Do you think girls should hide menstruation from the family member?	a. Yes b. No c. I am not sure
2.14	Do you support family planning?	a. Yes b. No c. I am not sure
2.15	Does anyone discuss family planning with you frankly?	a. Yes b. No c. I cannot remember

Part 3: The state of Adolescent Health		
Sl.	**Questions**	**Response**
3.1	Do you feel that you are growing up?	a. Yes b. No c. I am not sure
3.2	Have you been bullied due to your current height?	a. Yes b. No c. I cannot remember
3.3	Would you react in case of being bullied due to your height?	a. Yes b. No c. I am not sure

Part 3: The state of Adolescent Health		
Sl.	**Questions**	**Response**
3.4	Have you been bullied due to your current weight?	a. Yes b. No c. I cannot remember
3.5	Would you react in case of being bullied due to your weight?	a. Yes b. No c. I cannot remember

Part 4: The state of Pubertal Maturation for girls		
Sl.	**Questions**	**Response**
4.1	How do you feel comfortable explaining yourself?	a. A girl b. A woman c. Midst of a girl and a woman
4.2	Are you feeling your body is changing?	a. Yes b. No c. I am not sure
4.3	Please write about your body change (If yes)	Open-Ended
4.4	Do you track your body change?	a. Yes b. No c. I am not sure
4.5	Do you miss your schools/colleges/ universities due to health condition abnormality?	. Yes b. No c. I cannot remember
4.6	Are you willing to keep your body change secret from others?	a. Yes b. No c. I am not sure
4.7	Have you talked about your body change with anyone?	a. Yes b. No c. I cannot remember
4.8	If yes, with whom have you talked?	Open-Ended

Part 5: Pubertal Maturation for boys		
Sl.	**Questions**	**Response**
5.1	How do you feel comfortable explaining yourself?	a. A boy b. A man c. Midst of a boy and a man
5.2	Are you feeling your voice is changing?	a. Yes b. No c. I am not sure
5.3	Are you feeling your beard or mustaches are growing?	a. Yes b. No c. I am not sure
5.4	Do you feel embarrassed due to this change?	a. Yes b. No c. I am not sure

Part 6: Body Comfort among adolescence		
Sl.	**Questions**	**Response**
6.1	Are you satisfied with your current height?	a. Yes b. No c. I am not sure
6.2	Are you satisfied with your current weight?	a. Yes b. No c. I am not sure
6.3	Do you assume your childhood is better than now you are?	a. Yes b. No c. I am not sure
6.4	Do you feel embarrassed due to your body change?	a. Yes b. No c. I am not sure
6.5	Do you feel embarrassed during your body change?	a. Yes b. No c. I am not sure

Part 6: Body Comfort among adolescence		
Sl.	**Questions**	**Response**
7.1	Can you move freely?	a. Yes b. No c. I am not sure
7.2	Which is most important to you?	a. Your choice b. Family expectation c. None of them
7.3	Do you feel free to express your opinion?	a. Yes b. No c. I am not sure
7.4	Do your parents care about your opinion?	a. Yes b. No c. I am not sure
7.5	Can you independently decide over the following issues?	a. To attend after school/ college/ university activities b. To meet your friends c. To go to a playground to play with your friends d. To attend religious activities like praying
7.6	Do you believe you will be able to choose your partners in the near future without your parent's concern?	a. Yes b. No c. I am not sure
7.7	Do you believe you will be able to decide independently when to marry?	a. Yes b. No c. I am not sure

QUALITATIVE CHECKLIST

Topic Focus	Questions	Suggested Expansion Material
Changes and development due to puberty	• What changes did you go through, or what changes are you experiencing? • What did you think, feel and do about it? • When did you first fall in love or experience romantic thoughts about someone? • What changes do you think to occur in the case of girls and boys due to puberty? • Do you think the changes occur in the case of both genders? • Were you aware of the changes beforehand? If yes, how? • Where did you learn this information? • Do you have any idea about the connection between the changes and reproductive health?	Bodily changes, periods, puberty, nightfall, reproductive knowledge
Sex education in schools	• Have you received any sex education from your school? • How do you feel about the sex education that is provided in school? • Is it useful?	Issues taught, methods of teaching, appropriateness of lessons
STI and AIDS	• Are you aware of the term sexually transmitted diseases (STIs)? • Which are those diseases? • Do you know how AIDS is transmitted? If yes, how do you know? • How can AIDS be prevented? • Where did you learn this information? • To what extent do you think HIV is a risk factor for adolescents?	STIs, HIV

Topic Focus	Questions	Suggested Expansion Material
Family planning & contraception	• What is family planning? Why is it important? • What are contraceptives? What do you know about this? • Where did you learn this information? • What degree of discussion has taken place? Who led the discussion? • Are you aware of unprotected sex?	Effective use of contraception, protections used against pregnancy and STIs,
Gender diversity	• What is gender identity? • How many genders are there? • Do you think gender diversity is important? Why? • Where did you learn this information?	Gender diversity and relevant gaps in knowledge
Parents, family, and community members	• Have your parents ever talked with you about sex or any matters related to sex? • What about other members of your family or community? • Would you have liked your parents (elders)/other family and community members to be more open? • If yes, what issues do you think should be talked about? In what ways? • How important are parents (elders)/ other members of your family/ community as sources of information?	Awareness-raising, bridge gaps in knowledge, understanding perceptions
Gaps in knowledge	• Do you think that the information you have received has not been adequate? • What issues do you lack knowledge of? • Who or from where would you like to learn more about these issues?	Awareness-raising, bridge gaps in knowledge, understanding perceptions

CONSENT

CONSENT FOR PARTICIPATION

"SRHR Practice among the Adolescents: Evidence from the Adolescents of Dhaka City"

funded by Share-Net Bangladesh

I am …….. (Name) and providing my consent for participation on behalf of my son or daughter …….. (Name) studying at class …… (Number) in …… (Educational Institution).

1. I agree to let my son or daughter participate in a research project conducted by MD. Rafiqul Islam from Share-Net Bangladesh
2. I have received sufficient information about this research project and understand my son's or daughter's role in it. The purpose of his or her participation as a respondent in this project and the future processing of his or her data has been explained to me, and it is clear to me.
3. Participation as a respondent in this project is entirely voluntary. There is no explicit or implicit coercion whatsoever to participate.
4. Participation involves being interviewed. The session will last approximately 30 minutes
5. My son or daughter has the right not to answer questions. If he or she feels uncomfortable in any way during the interview session, he has the right to withdraw from the interview and ask that the data collected before the withdrawal be deleted.
6. I have been given the explicit guarantee that the researcher will not identify the respondent by name or function in any reports using information obtained from this interview, that confidentiality as a participant in this study remains secure. Personal data will be processed in full compliance with anonymity.
7. I was assured that this research project has been reviewed and approved by Share-Net Bangladesh. The principal investigator can be contacted if needed at mrislamju2015@gmail.com.
8. I have carefully read and fully understood the points and statements of this form. All my questions were answered to my satisfaction, and I voluntarily let my son or daughter participate in this study.
9. I will receive a copy of this consent form to the interviewer as an automatically generated mail.

For further information, please contact:
MD. Rafiqul Islam at mrislamju2015@gmail.com

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