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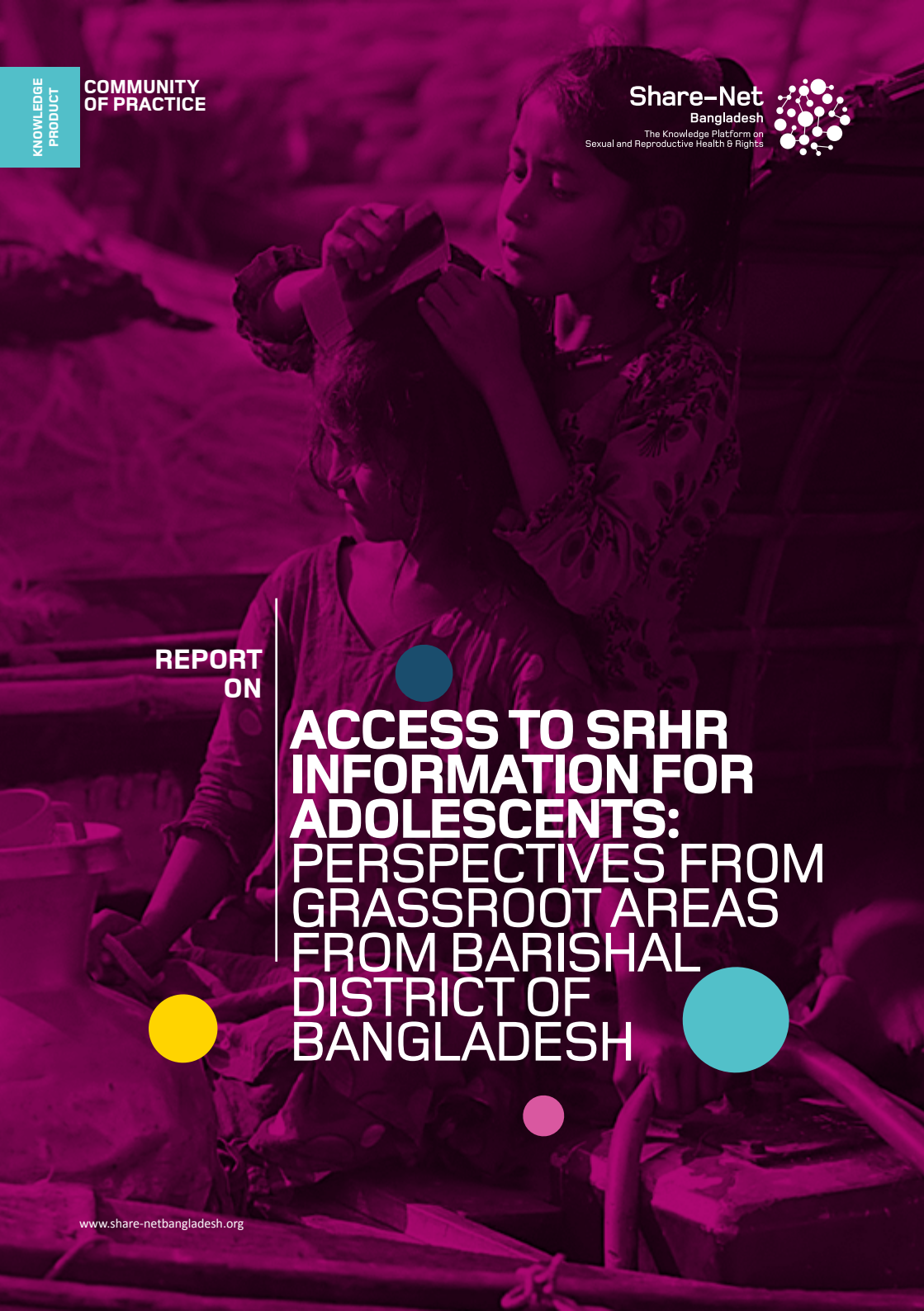

REPORT ON

ACCESS TO SRHR INFORMATION FOR ADOLESCENTS: PERSPECTIVES FROM GRASSROOT AREAS FROM BARISHAL DISTRICT OF BANGLADESH

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ACCESS TO SRHR INFORMATION FOR ADOLESCENTS: PERSPECTIVES FROM GRASSROOT AREAS FROM BARISHAL DISTRICT OF BANGLADESH

EXECUTIVE SUMMARY

Bede, riverside dwellers, and slum dwellers are three competing grassroots and marginalized communities. Their socio-economic situation is comparatively poorer than the mainstream communities. SRHR, being a cross-cutting concept, is not yet understood from their perspectives. Almost no evidence stating their current knowledge status about SRHR among adolescents is available. From this research gap, the study tries to understand their access to knowledge on SRHR and the respective adequacy as well as appropriateness. Two basic study questions addressed here are to understand the access to SRHR knowledge and to understand the adequacy as well as the appropriateness of the study. From a methodological point of view, this study adopts Key Informant Interviews (KIIs), and Focus Group Discussions (FGDs) as study tools while thematic analysis is the analytic frame for this study. Through this thematic analysis, this study has come to the finding that the knowledge status is very poor among grassroots and marginalized communities in Barisal. The related information available to them is neither appropriate nor adequate at all. They are just concerned that they are going through a change, but they have neither detailed guidelines nor a detailed understanding. The key stakeholders are concerned with this reality. But due to poverty and very limited access to education, they overlook SRHR and concentrate more on poverty. As a result, their prime source of information remains pornography and some vague narrative from their surroundings. Based on this finding, this study suggests a holistic approach to intervention. This holistic approach must include a comprehensive understanding along with the participation of other stakeholders. Because the existing interventions, for example, family planning programs, can at best cover the knowledge issues but cannot address them completely. More specifically, the modes of birth control or menstrual hygiene are covered under the fraction of knowledge issue.

Partial understanding cannot be a solution in this case.

1. INTRODUCTION

1.1. THE GRASSROOT SOCIETY OF BANGLADESH

The word “Grassroot” is a newly emerging term to define the marginally excluded people’s socio-economic realities. The Merriam-Webster dictionary defines it as “basic or fundamental,” operating at the grassroots, and not adapted to the existing facilities or operations. For the current study’s purpose, this study identifies it as the marginalized population who are excluded from the success of mainstream development effects. Despite many development activities, Bangladesh has plenty of such communities. There are two types of such grassroots communities: plainland grassroots communities and grassroots communities at the hill tracks. Much more division is possible among the marginalized and the grassroots communities, including the plain land minority, the Chittagong Hill Tracts (CHT) minority, the economic minority, the social minority, and so on. For simplicity, this study adopts marginalized as well as grassroots communities under the single definition of “marginally excluded from the mainstream society”.

This study has adopted three such communities to address for. They are the Bede community, riverside community, and slum community as the representative of the grassroots and the marginalized community. This study comments on the entire marginal and grassroots society by showing evidence from these three communities.

The Bede is an Indo-Aryan nomadic ethnic community living in Bangladesh. They live, travel, and earn on water, specifically river water in the Barisal Division of Bangladesh. For this water-centric way of living and nomadic nature, they are also known as the “water Gypsy or River Gypsy (Maksud

& Rasul, n.d.). They live on snake-catching, charming, and selling lucky feathers and herbal medicines (Shejuty, 2018). 98% of them live below the poverty line, while 95% of their children do not attend school (Maksud & Rasul, n.d.). Due to the absence of any permanent address, they cannot obtain bank loans or loans from any microcredit institution (Maksud & Rasul, n.d.). Beyond all of those, they are deprived of access to basic services and rights (Akter & Kalam, n.d.), victims of urbanization (Mahmood, 2019), have no right to property (Khanam, 2020), and have no access to information (M. A. Rahman et al., 2022).

Bangladesh is a riverine country, as 230 rivers have flown through the country according to an estimate by the Bangladesh Water Development Board, Bangladesh (Hossain et al., 2014). The number of populations living along the riverside is not yet estimated but we can assume this number to be huge due to the large number of rivers flowing over the country. One of the larger fractions of this riverside community is the Charland dweller. For instance, the dwelling system of the fishing community on the Bank of Karnaphuli is characterized by higher population density, a compact settlement pattern, poor infrastructure, a lack of proper utilities (like gas, sanitation, etc.), disaster vulnerability, higher maintenance costs, and inadequate future expansion opportunities (Haque & Das, 2020). Despite the rise of food production in the countries, they are not capable of maintaining food security, especially for women (Masud, n.d.).

According to the slum census of 2014, there exist almost 14000 slums across the country where more than 1.1 million people live. Just four percent of them live in a pucca (brick/cement) house, while 87% of them are landless. Poverty (28.76%) and a job-seeking tendency (50.96%) have tempted them to live in slums. Beyond this statistical reality from the slum census of 2014, the slum dwellers are continuous

victims of less access to WASH facilities (Alam & Mondal, 2019; Nowreen et al., 2022), unsafe food and water especially for children (Mostafa et al., 2018), domestic violence against women (Chowdhury et al., 2021), deprivation in a different form (Patel et al., 2019), depression (Azad et al., 2019), and, early marriage (S. C. Biswas et al., 2020b).

1.2. THE SRHR KNOWLEDGE STATUS AMONG ADOLESCENTS

Historically, the International Conference on Population and Development (ICPD) in Cairo brought attention to Sexual and Reproductive Health and Rights (SRHR) and this conference in 1994 marked a paradigm shift in the population control program by including SRHR into the development paradigm as a part of the population control program (Glasier et al., 2006). Thus, the birth of the modern SRHR movement takes place. A Program of Action (PoA) was developed then and later adopted by a total of 179 nations (Royce A. Fincher, 1994). But the Millennium Development Goals (MDGs) did not include this one explicitly (Glasier et al., 2006). On the other hand, SDGs had adopted more vividly after phasing out MDGs and PoA (Tangcharoensathien et al., 2015).

In Bangladesh, 20% of the entire population is adolescent according to the country census 2011. They were introduced to sexuality for the first time, as this time is the bridge between childhood and manhood or womanhood. Unfortunately, lack of knowledge is prevalent among them (Hashem, 2009), although this lack of knowledge does not mean that they are at all unfamiliar. But in literature, the importance of SRHR has been addressed quite well. For instance, O'Leary et al. (2021) claim that proper knowledge assists girls in avoiding unintended pregnancies, attaining higher levels of education sharing, and their lifetime well-being with the subsequent generations. But the pathways to attaining that knowledge are not normalized

within the social context of Bangladesh. Kamruzzaman et al., (2022) identified five clusters of barriers, and these barriers include lack of teacher training and experience in SRHR class lectures, as well as parental ignorance, social stigmas, social taboos, and cultural rigidity; lack of textbook information; combined classes and age discrepancies between teachers and students; misuse of appropriate technology; and sometimes, male teachers giving SRHR lectures to female students and female teachers giving SRHR lectures to males.

The situation becomes worse when female teachers are taking classes with male students and their lessons include SRHR components like family planning. Due to extreme shyness, female teachers keep skipping teaching SRHR components. Using a Structural Equation Model (SEM), Methun et al., (2022) showed evidence that students' knowledge of pubertal changes is associated with gender, education, age, and parental limit setting on daily activities, particularly in the rural areas of Bangladesh. Sexuality education is not workable among adolescents as the teachers perceive sexuality-related topics as 'excessive','unnecessary', and 'inappropriate' in school settings (Khan et al., 2020). The existing cultural sensitivity is a culprit in adopting SRHR knowledge among adolescents (Roodsaz, 2018). Rapid knowledge transmission among adolescents is one of the prominent pathways (Meijers et al., 2022). Later, A. Williams et al., (2022) has done a comprehensive literature review and identified four types of research gaps in Adolescent Sexual and Reproductive Health (ASRH) related issues. These gaps are coverage gaps, under-reporting gaps, and substantive gaps. This study also found unmarried or non-married women were also excluded from fertility and health surveys, as were adolescents under the age of 15, who are not typically included in national fertility and health surveys, and adolescents and youth in vulnerable situations, such as refugees and youth on the streets.

Information on the prevalence of sexual activities, and induced abortions are extremely limited. Undocumented Human Rights Dimensions of ASRH, Health impacts of adolescent pregnancy and childbearing, Long-term economic impacts of adolescent childbearing, Adolescents' pregnancy and childbearing intentions, Reasons for unmet need for contraception, Other issues including sexuality education, sexual identity, sexual orientation, bullying, and same-sex behaviour are also less researched issues according to the point of view.

1.3. THE SRHR KNOWLEDGE AND ADOLESCENTS IN THE GRASSROOTS SOCIETY IN BARISHAL DISTRICT

The previous two sections establish two scenarios. The first one is that the socio-economic reality among the marginalized and the grassroots society is quite poor despite their number. The second one is that SRHR is important for adolescents.

The existing literature provides some evidence that mainstreamed adolescents might not have the appropriate knowledge in this domain. The case of Holy Cross College can be an example of this regard (Das & Roy, 2015). For instance, A. Williams et al., (2022) mentioned that Youth in vulnerable situations, such as refugees and youth living on the street are typically excluded from health research. In this regard, (Hiddink & Baatsen, n.d.) claimed the existence of no studies on gender-based violence; fertility care; prevention and control of HIV/Sexual Transmitted Infections and sexual functioning concerning indigenous people in Bangladesh. In this context, there exists no literature evidence on the SRHR context of the adolescents who belong to the Bede, riverside and slum community. In this point, some narrowly defined issues like early marriage (S. C. Biswas et al., 2020a), pragmatic choices (Rashid, 2011) and lifestyles (Rashid, 2011) are discussed which are far away from the original context of SRHR. Thus,

the existence of this huge number of these marginalized and grassroots communities along with their poor socio-economic realities while we have no literature evidence for ASRH rationalize to study SRHR knowledge status for the adolescents of those communities.

2. STUDY DESIGN

2.1. THE STUDY OBJECTIVE AND STUDY QUESTIONS

Initially, this study covers access to SRHR information for adolescents and the need for accurate quality information on SRHR. Firstly, there is a need to reach adequate and appropriate SRHR information to the grassroots areas. Secondly, those adolescents will be adults in the coming days. We need to enlighten those adolescents with adequate and appropriate SRHR information from this perspective. These two-fold realities rationalized this study.

In line with the study objectives, this study possesses two research questions. The first research question is "How is SRHR knowledge transferred to adolescents at the grassroots?". Under this research question, this study seeks to understand the knowledge transfer process among adolescents.

As an extension of this study question, this study seeks to explore its second study question. This one is titled "How much is adequate and appropriate knowledge received by those adolescents?". This research question goes firstly a brief qualitative survey on the existing knowledge pattern. Then, this study compares based on adequacy and appropriateness. This study takes adequate information and requires an optimal scenario in which they have enough information, and do not need more at all. And this information is right in the sense that

they do not make any harm at all while this study defines this righteousness as appropriateness.

The last study question is related to the programmatic interventions in the form of recommendations. Thus, the research question becomes "What should be the programmatic interventions for reaching them with adequate and appropriate SRHR knowledge?"

2.2. THE STUDY HYPOTHESIS

This study contains three different study hypotheses based on three study questions. The first hypothesis is "The process of how that SRHR information gets transferred is not fair". In this hypothesis, fairness carries a special meaning. This process denotes that the information-obtaining process has some leakages. From these leakages, several inappropriate knowledge transfers to them. The second hypothesis is an extension of the previous one. This hypothesis titled "SRHR knowledge as transferred to those adolescents is not adequate and appropriate". This denotes that the adolescent under this study scope receives inadequate and inappropriate knowledge. The last hypothesis is an optimistic point of view. This point asserts that the appropriate programmatic intervention can change the current scenario with inadequate and inappropriate SRHR information.

2.3. THE STUDY CONCEPTUAL FRAMEWORK

This study divides the entire scenario into two different realities. They are the current scenario with inadequate and inappropriate information and the desired scenario with adequate and appropriate SRHR information. In the desired scenario, appropriate and adequate knowledge is transferred to the adolescent and turns no malpractice to them. The shift

from the existing scenario to the current scenario is a must. This shift is possible through a programmatic intervention. The entire study is based on this conceptual scenario.

In this study, this study divides the adolescents into two groups of early and late adolescents and they are turned into another two divisions of boys and girls. Their detailed definition has been clariid in the next section.

2.4. THE STUDY METHODOLOGICAL FRAMEWORK AND STUDY PARTICIPANTS

The primary stakeholders are entertained through FGDs while the secondary stakeholders are through IDIs. The primary stakeholders include Early boy adolescents, Late boy adolescents, Early girl adolescents, and Late girl adolescents from three communities of Bede, riverside, and slum communities. According to the definition of World Health Organization (WHO), this study defines a person aged between eleven and fourteen years as an early adolescent while adolescents aged from twelve to eighteen years old as to be late adolescents.

On the other hand, the Community population, Community leaders, School Teachers, LGIs representatives, NGO workers, and Others are the secondary stakeholders also from these three communities are secondary stakeholders. The number of FGDs and KIIs from each group and stakeholder is one leading to the total number being thirty. All of those sessions have been recorded with proper consent and next, we have transcribed those also. These transcriptions will be then translated into English for coding. Based on those coding through MAXQDA, we have built the narratives to report into the final draft.

2.5. THE ETHICAL CONSIDERATION

The study has maintained ethical and pandemic counterparts. The moral companion provides safety, a person or community-centered approach, adapted methods, personal security and need basis, anonymity, no harm principle, and free exit to the study.

3. FINDINGS

3.1. FINDINGS FROM FGD

3.1.1. EARLY BOYS ADOLESCENTS AND GIRLS ADOLESCENTS (AGED BETWEEN 10 TO 13)

The early adolescents from the Bede community define their views on growing up as being taller, having swelling bodies, and having a strong desire to get married along with an attraction to weeds. In contrast to this scenario, the girls from the same group start to feel shy to communicate with the boys of the homogenous age groups. These boys get SRHR-related knowledge from the surrounding community members while in the case of girls, they receive some information from their mothers. These boys and girls are not in the coverage by formal education, which is why no mode of sex education is available to them. This “no education” scenario has led them to be ignorant of the appropriateness of what they view. The girls perceive they know as they need to know and further learning will come later. These boys and girls have no appropriate idea about Sexually Transmitted Diseases (STDs) while girls mix this with some non-STDs like transmitted diseases (or non-transmitted diseases) like COVID-19, allergies, and even diarrhea. They do not have a proper idea of the differences between sexually transmitted diseases and diseases that are not sexually transmitted. In this regard, some girls perceive diseases which are not sexually transmitted, for

example, allergy or diarrhea, as being sexually transmitted one. But they can correctly mention at best one STD and that is HIV. The boys do not have any idea about family planning and they perceive it to be anything that occurs after getting married. The girls discern it as GOD's will about the number of children in any family. These girls prefer larger families as they can generate more income. In this regard, one of the Bede girls states,

"More children, more work, and more income"

Issue	Bede Community	Riverside Community	Slum Dwelling Community
Body Change	Yes, They acknowledge	Yes, They acknowledge	Yes, They acknowledge
Sex Education	No	No	No
STDs	No clear concept	No clear concept	No clear concept
Family planning	No clear concept	No clear concept	No clear concept
Talk to the family members	Both boys and girls	Only girls for menstruation	Only girls for menstruation
Shyness	Yes	Yes	Yes

As the marriage is evident to them, they perceive the appropriateness of the family planning knowledge will assist them in marital life.

The boys talk with only their grandparents while the girls talk with their mothers, sisters, and grandmothers. They feel shy to talk with anyone beyond this group. The list of topics includes

just cleanliness for the boys while this list is not specific for the girls. Boys' parents are not cordial with their sons but the scenario is the opposite in the case of the girls. They feel shy and they get insulted if asked about any specific issue as the peer groups perceive that it is not the appropriate time to know those issues. Boys are more curious to know whether masturbation is good or not. On the contrary, the girls are more willing to know about stomach pain, leg pain, and any other problems during their masturbation as well as the cure for those. It is easy for the boys if they can discuss those issues with their friends while girls prefer the NGO workers as the mediating persons to inform these issues.

The case of the riverside community is a bit different as their socio-economic norms are mostly generalized compared to the mainstream community. As being closer to the mainstream communities, they view body change in more generalized ways. The cases of the boys include the same as the Bede community boys and they feel they act sometimes mysteriously. This mysterious feeling denotes a peculiar feeling when they feel their body does not act as it acted during their childhood. They can identify this feeling but unfortunately, they do not have any factual explanation for this mysterious feeling at all.

On the other hand, the girls who try to dress as adult women are supposed to include more attraction. The source of knowledge for the boys is their peers while the girls can learn from their mothers, elder sisters, and fathers in some rare cases. No formal sex education is prevalent even if they are under education coverage in the form of formal or non-formal education. They have almost no ideas about STDs and they can remember just HIV as a possible candidate for the STDs as they read it in their textbooks. Girls perceive some other non-STDs like allergy, Covid-19, or influenza as similar to STDs. They can rightly identify the definition of family planning as it is included

in their textbooks but how much is covered by the scopes of family planning is not clarified to them in the broader sense the real coverage is completely unknown to them. They perceive the real coverage of family planning is far larger.

Boys are interested to know from their good parents while girls are seemingly reluctant not to be informed about SRHR issues. But girls prefer their mothers even if they have learnt almost nothing at this point. Unfortunately, what they want to know is not clear to them.

Like riverside communities, slum-dwelling communities are next to mainstream communities. Their view toward body change is almost similar to that of the riverside communities. But in this regard, girls are more willing to have friends of the opposite gender. The sources of information for the boys are mobile phones, friends, and community members excluding family members. On the contrary, girls receive related information from their mothers, grandmothers, and elder sisters. Despite the education process through formal and informal education, their mode of sex education is pornography while the girls have no idea about it. They learn sexuality from watching pornography and it has got established to them as the sole mode of sexual education but the girls have less idea about it. They do not perceive whether they have the information at all. That is why the appropriateness of that information is far away. Like the other two communities, they are ignorant of STDs. Only girls can mention HIV as one potential candidate for STDs and they know it from the advertisements telecasted on Television. Eventually, One of the boys' states

> *"Sexual disease can be if one goes for staying in a hotel room or for room dating"*

The boys prefer large family structures while the girls prefer the complete opposite. In this regard, one of the boys states,

"Large family is good. Because all the members can live with each other. For small families, the relatives might take away their properties including land"

On the other hand, one of the girls states,

"The costs are minimal for the small family structures while the children can be reared with cordiality "

The differences between these viewpoints are due to their differences in perceptions. This difference indicates that the respective boys and girls are not receiving the same social insights. They are in doubt regarding the righteousness of the information they are receiving. Boys prefer school teachers for receiving the right information regarding family planning while girls mention family members along with those school teachers. Boys do not talk with anyone except the elder community members excluding their family members. In this regard, one of the boys mentions

"Parents do not share much with us as we are young. After marriage, the mother-in-law shares those pieces of information with our wives "

But the girls doubt if they receive the required information, they can be misguided. One of the girls' states

"This is not the right time to know. We can be misguided and can be in affairs with boys"

Despite that rhetorical scenario, the boys are interested to know about masturbation while the girls have no idea what they should know. And they rationalize not talking with almost anyone as their age is too little. Boys fear they can be beaten by their parents even if they dare to ask. On the other hand, the girls perceive parents will assume their daughters have ruined if they ask. Shyness is a factor here. On the other hand, they think their parents will talk when they get comparatively

older. Despite all of those, they perceive they are getting the right information while the girls perceive they have much more to learn in this regard

3.1.2. LATE BOYS ADOLESCENTS AND LATE GIRLS ADOLESCENTS (AGED BETWEEN 13 TO 18)

For the Bede community's late adolescents, their views do not change even when they are the adolescent's age. For the boys, they feel more willing to get married. One of them mentions

" I feel more willing to get married "

Issue	Bede Community	Riverside Community	Slum Dwelling Community
Body Change	Yes, They acknowledge	Yes, They acknowledge	Yes, They acknowledge
Sex Education	No	No	No
STDs	No clear concept	No clear concept	No clear concept
Family planning	No clear concept	No clear concept	No clear concept
Talk to the family members	Both boys and girls	Only girls for menstruation	Only girls for menstruation
Shyness	Yes	Yes	Yes
Sources of the information (Boys)	Friends and pornography	Friends and pornography	Friends and pornography
Sources of the Information (Girls)	Female family members and romantic movies	Female family members and romantic movies	Female family members and romantic movies

But for the girls, shyness for the boys rises and their malnutrition cycle starts at this stage almost. The sources of knowledge remain the same at this point. But pornography is introduced for boys while girls know from romantic movies, almost equivalent to adult-rated movies to some extent. At this time, they become more confident in what they know. The knowledge regarding STDS remains the same but the girls get informed through Non-Governmental Organizations' incentives like Anada Schools. But they have just known they can be the victims of STDs if they get involved into extra-marital sexual intercourse. But at these stages, they are enthusiastic to know the details of such STDs. The boy's knowledge is concentrated on two points; they have to get married and they have to give birth to children. But girls are a bit better informed at this point. They prefer few children as it minimizes the child-rearing cost and they emphasize taking children according to their income-generating capacity. Condoms, pills, and injections are known family planning methods among girls. Boys perceive they know enough but this confidence is not realistic while girls are more prone to know things in detail. They acknowledge they need to know more with proper detailing. Boys are more interested to know the methods of sexual intercourse while girls are more interested to understand the process of giving birth to the child and the feminine disease accompanied by the respective cures. They talk with similar people as they used to earlier. But the girls are less enthusiastic as they perceive they will know single thing after getting married. One of them mentions

> *"Why shall we talk? We can know everything after getting married"*

Excluding STDs, they perceive that they have working knowledge in SRHR. Due to their floating nature over the rivers, the girls prefer the floating education centers as well as hospitals as the prospective knowledge-sharing centers.

A similar echo is found for the riverside community also. The boys perceive the constant view regarding their body change. But some fantasy works in their thinking process. One of them states

> *"I do not know why this is happening. I am fantasizing about my body"*

But for the girls, a change in body shape along with the start of menstruation is noted. The sources of the information is still similar but just internet and the pornography adds here. Boys take religion as the guideline at least for the sake of cleanliness as one of them states:

> *"The body is to be cleaned at least once in every forty days. Unless the body becomes un-purified".*

The sources of information among those boys are still similar while biology textbooks and NGO activities add extra sources of the information. But the superstition is prevalent herewith as one of them states:

> *"Masturbation decreased hormone and falls the sexual intercourse time dimension"*
> *"If they do not use Facebook and messenger, there will be no HIV"*

Even though they have some thoughts which are just superstitions, they think they know all and they have nothing more to know. On the other hand, girls include cervical cancer and breast cancer on the STD list. They correctly identify the need for cleanliness and safe water drinking during the menstruation cycle. But mistakenly, they portray the absence of those as the factors of HIV while they claim those as the factors of sexual disease is true. They claim being married to any migrant workers might spread HIV among them. One of them states

"Being married to the migrant workers residing abroad might contaminate them with HIV "

The source of the family planning information is their social science textbook. But boys are seemingly less carefully informed on this issue. They perceive giving birth to the children as God's will and they perceive good family planning as similar to having a loyal wife. But as contraceptive methods, they are informed of condoms, and pregnancy pills and they also perceive these as the tools for preventing unwanted pregnancy. Two of the states:

"The sons and daughters are the sole gifts of God"
"Family planning is to have a loyal wife"

For the question of family planning, they perceive they have to know more. But shyness to the family members is still a barrier in this regard. The stakeholders with whom they talk are still similar to them. The discussion topic for the boys includes masturbation, and the detailing of the sexual relationship while the girls are more reluctant to talk about family making, the process of giving birth, and after-marital relationships. One of the boys state

" We are worried. Will we face any problem while giving birth to children?"

Girls are forbidden to mix with married women and they may get ruined if they communicate with them frequently as their parents perceive. Girls sometimes face some physical complexities relating to the SRHR but they have none to talk about. In that reality, they do not eventually know where to seek advice in this regard. Girls are more reluctant to understand breast cancer or cervical cancer. Boys still prefer good friends along with websites and books. Girls prefer female biology teachers, mothers, and health workers.

As stated before, the slum dwellers are one of the marginalized and the grassroots community. The view toward body change is also similar. For the boys, the willingness to masturbate or to be in a relationship is the new dynamic. They also notice they are not growing like before. One of them notes that

" I am not getting taller like before."

But the for the girls, everything remains the same from this point of view except the start of the menstruation cycle. The sources of information at this point are still similar. But girls start to be in touch with the health workers and NGO workers who educate them on this issue generally. The situation of sex education is still similar. But the boys are confident that pornography provides a solid knowledge of what they need. One of them states

"Pornography contains everything we need as well as everything we cannot understand. We can understand every single thing through watching Porns"

The differences between STDs and Non-STDs are not clear among them. One of the boys states

"Piles and HIV are sexual diseases"

Like sexual education, advertisements are the single source of knowledge for family planning among boys. But here, they just acknowledge the importance of the smaller family. Some of them state

"No more than one son or one daughter"
"If the first one is son, everyone surrounding us becomes happier. Small family is a happy family"

Due to the existing patriarchy, they prefer sons over daughters. On the other hand, the girls can mention contraceptives like condoms, pills, or injections. They perceive taking one or two

children means a planned family. For family planning, the boys get no knowledge support while the girls are under the development umbrella of the NGOs. But they feel shy while talking about those, their society can portray them as ruined ones. Boys and girls have a common topic on which they love to talk. This one is the process of sexual intercourse and making the partner happier. Both of them felt shy to talk about their desired topics. As a result of shyness, boys seek to learn from pornography. The boys are curious to know why men lost their interest in their wives after their marriage. On the other hand, girls are more likely to understand contagious diseases as well as the complexities related to menstrual complexities.

3.2. FINDINGS FROM KIIS

For all three communities, the community leaders almost correctly identify the basic changes which adolescent boys and girls go through. This list includes basic body changes, voice changes, beard growth, the start of the menstrual cycle, and reproductive capacity growth. They identify the sources of knowledge are the surrounding community people, including some family persons, and so on. They also notice that sources of sex education are absent for the Bede community while the other two groups can learn through NGO workers or classmates. According to their point of view, their knowledge is just concentrated on the naming of some STD diseases while all of these mentioned diseases do not actually belong to STD groups at all. But the parental views are just concentrated on advice if any menstrual situation arises. Shyness and the lack of education are the core impediments herewith talking all with the sons or daughters mostly. The SRHR being a cross-cutting development agenda is not important to them as they are mostly concerned with poverty. But all of them acknowledge the contribution of NGOs in terms of knowledge products.

4. DISCUSSION

4.1. SRHR KNOWLEDGE TRANSFORMATION PROCESS

4.1.1. BODY CHANGES AND DEVELOPMENT DUE TO PUBERTY

The issues of body change are common among the three competing communities. They correctly identify which changes they are going through. Unfortunately, they do not have any appropriate instructions or guidelines regarding what they should do. This scenario led them to be embarrassed. Shyness is the core factor and that is why community leaders or other senior stakeholders remain silent. Eventually, poverty is a serious concern that impedes them to prioritize SRHR at all. From this point of view, these stakeholders remain silent in the whole process of their pubertal development. This reality does not mean that they are informed at all. They know the existing scenario but they are taking ASRH as a luxury due to poverty and shyness.

4.1.2. SEX EDUCATION

Sex education is absent among these adolescents whether they are under any of the education processes or not. The stakeholders know this but they are not ready to acknowledge that any knowledge can be shared in the domain of sex education. They take sexuality as a normal scenario but they did not acknowledge something can be taught regarding this one. Eventually, the righteousness of their understanding of those stakeholders on SRHR is also in question. In this perspective, friends and pornography have become the sole source of their knowledge. The understanding of their friends as well as the validity of the contents shown in the pornography is also in high doubt. Some NGOs are educating them but they concentrate on only menstrual hygiene leaving the boys alone.

4.1.3. SEXUALLY TRANSMITTED DISEASE

In the case of STDs, they are just informed there do exist some diseases that are related to their organs used extensively for sexual intercourse. They do not know those and the STDs are not the same. The only disease they can name is just HIV.

4.1.4. FAMILY PLANNING

Like previously two stated issues, they have no concrete idea on family planning at all. Bede boys are in the favor of the larger families as they perceive the larger family will offer them more earning protection. But the remaining portion argues against them. They perceive the number of family members should be compatible with the earning level. As poverty is a common characteristic of their communities, they prefer a smaller family size.

4.1.5. PARENTS, FAMILY, AND COMMUNITY MEMBERS

Family members and community members know how to feel at that stage with every single detail if we exclude the technology-oriented changed reality. But they do not consider it. Eventually, they perceive that menstruation and its associated complexities are the ones only that can be talked about before their marriage. Eventually, they assume they are thought to be ruined youth if they dare to talk.

4.1.6. KNOWLEDGE GAP

Adolescents just know they are going through some changes and their bodies are part of themselves. Despite this, they do not know what they know and what more they need to know. NGO-centric knowledge intervention is concentrated on the girls and they just cover menstruation and associated complexities. Leaving the boys alone has made them rely on what they assume from either pornography or what they hear from their classmates.

4.2. ADEQUACY AND APPROPRIATENESS

The adolescents have very little information on SRHR and they are not either completely right or enough to lead a normal life from SRHR point of view. Incidents of poor information by quality and quantity are known to the relevant stakeholders. But this informed state does not make the stakeholders conscious of taking any step at all. Because these stakeholders perceive that these communities have some more important sectors on which they are concentrating.

The inadequate information makes scope for inappropriate information. For instance, they possess some sort of superstition and ideas which are harmful to them. Eventually, we have already observed they have no ideas on the detailing of family planning or STDs and that scenario puts them in reality while they can be the prey of STDs. This one will lead to tempting with having larger families in the near future to some extent. From this subjective point of view, this study argues that the information available to them is neither adequate nor appropriate at all. The stakeholders are informed of the adverse realities of the current scenario but they do not emphasize those.

5. LIMITATION OF THE STUDY

This study has some serious limitations that can be overcome through the scoping up of this study. Being a qualitative one, this study cannot comment on how much adolescents know how much. For this reason, an intervention project cannot be designed based on this study and this study cannot be used as the baseline for the project implementation. But this study rationalizes the need for such a project. Another serious limitation is that this study cannot go for the component detailing at all. The adolescents know too little that more

depth cannot be afforded at this point. These two limitations can be minimized simultaneously by commissioning a baseline study and a cohort study. We expect these like the mainstream one (O'Leary et al., 2021), proper knowledge assists girls to avoid unintended pregnancies, attain higher levels of education, and their lifetime well-being with the subsequent generation for the grassroots and the marginalized ones,

6. RECOMMENDATION AND CONCLUSION

6.1. RECOMMENDATION

At this point of the study, we propose a holistic programmatic intervention. We have already viewed that there exist some interventions through NGOs. But these interventions lack a comprehensive approach. On the other hand, some NGO incentives partially address SRHR and often address family planning issues. Addressing SRHR partially in different development interventions cannot cover all of the relevant issues under the domain of SRHR at all. For example, the programs concentrating on family planning are usually found to get missing the components of male SRHR components. That is why we need to have a holistic approach to addressing SRHR issues. From this point of view, this study argues for a programmatic intervention while a programmatic intervention can be holistic or cannot be. Thus, two basic characteristics of interventions need to be holistic as well as multi-stakeholder-centric. In this point, the possible holistic intervention can be knowledge centric having the components of establishing a knowledge channel and we expect that the transformation of the proper knowledge on SRHR to the adolescents will resolve the current phenomenon of inadequate and inappropriate knowledge among the adolescents

6.2. CONCLUDING REMARKS

This study reveals three points. Firstly, despite some socio-economic anomalies among those three communities, the adolescents of these communities have both inadequate and inappropriate information on SRHR. Secondly, the relevant stakeholders are informed but they are doing nothing as they perceive other issues to be more concentrated on. The last point is that we need some interventions with a holistic approach. We need to acknowledge that the partially concentrated programs or the programs leaving the boys alone cannot resolve this issue completely.

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