Volume: 35, Issue: 1
Page: 96-111
2024

International Journal of Science and Business

Journal homepage: ijsab.com/ijsb

A Study on Practice of Reproductive Health Care Facilities and Family Planning Decisions of the Rural Adolescent in an area of Bogura District, Bangladesh

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Abstract

Adolescent's reproductive health is a serious concern in Bangladesh. The present study is based on primary data collection and in-depth interviews of 150 rural adolescent females of Fulbari and Baiguni villages of Bogura district. The objectives of the study were to assess the level of knowledge attitude and practice on reproductive health issues, to assess the socio-demographic features of samples and to explore the level of knowledge & awareness to demonstrate the role of the information & education (media, counseling, services facilities) in the management of reproductive health issues among rural adolescent females. The mean age of the respondents were 16.2 years. School enrolment is still low (46%) and dropout rate is high (32%). A large number of rural adolescent females of the study area have been found to discontinue education after a few years of schooling. The data further shows that, in TV 7.31% attending health education and 12.19% to family planning program. More of the adolescents (60%) were aware of all least one family planning methods (Oral Pill). However, it is obvious that knowledge of various methods of contraception does not imply that the respondents actually knew how to use these methods effectively. The highest three methods they can named were oral pill 60%, Injection 35% and Implant/ Norplant 18.67%. Among all 72.64% were not known or received any information about the management of menstruation before their first menstruation. The study revealed that 72.41% of adolescent's females, those were suffering from at least one complication or problems of menstruation and were not visited or seeking any consultation or treatment from any service providers available. Only 18% of them seek treatment or consultation from the service providers. Among these sick adolescents' females who attended for consultation or treatments, 83.33% were not satisfied while only 16.67% express their satisfaction on the health care services. The social and religious constraints are strict in the culture and Islamic ideals of Bangladeshi people where the majority of whom still live in joint families. The study indicates that the rural adolescent females are poorly informed about most of the reproductive health issues. There also exist important misconceptions regarding healthy management of menstruation. Besides, there is big gap between their knowledge, attitude and practice. Parents, Guardians, teachers, religious leaders and community leaders (they are main gatekeeper) concern regarding management reproductive health issues of rural adolescent females.

IJSB
Accepted 20 March 2024
Published 22 April 2024
DOI: 10.58970/IJSB.2358

ISSN: 2520-4750 (Online) 2521-3040 (Print)

Keywords: *Knowledge, Attitude, Reproductive healthcare, Adolescent, Puberty.*

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Introduction

The Latin verb "ADOLESCERE," which means to grow and mature, is where the word "adolescent" originated (Bosch, 2005). The transitional stage between childhood and adulthood known as adolescence starts with the changes brought on by puberty and ends with the acceptance of adult roles and responsibilities (Field, 2004). In Bangladesh, adolescents make up about 25% of the population (BBS, 2018). Due to a lack of fundamental knowledge about their bodies, sexuality, contraception, and sexually transmitted infections (STIs), particularly HIV/AIDS, this sizable demographic is ill-prepared for sexual and reproductive life (Nahar, 1999).

By preventing and treating reproductive health issues, reproductive healthcare services enhance reproductive health and well-being (WHO, UNFPA, UNHCR, 1997). The term "reproductive health approach" refers to the following: individuals who are able to procreate and control their fertility; women who can safely carry a pregnancy to term; successful pregnancy outcomes in terms of mother and child survival; and couples who can engage in sexual activity without fear of becoming pregnant or ill (UN Doc, 1995). Ensuring that the quality of services is improved, especially from the user's perspective, is a crucial consequence of establishing reproductive health initiatives (UN Doc, 1999).

Since women are the program's main beneficiaries and face the most barriers to accessing health care, the program is centered on them (Bhuiya et al., 2000). Men's involvement and the promotion of responsibility should be prioritized equally (Bhuiya et al., 2004). The necessary services ought to be rendered with sufficient attention and quality, however Bangladesh mainly lacks these services because the country lacks the necessary infrastructure, hence the services are rendered on a small scale (Thapar et al., 2004). Although Bangladesh's current infrastructure is not suitable to provide comprehensive reproductive health services, the reproductive health agenda can only be achieved in a situation where the client's needs come first and the program personnel are motivated to meet those needs (Nahar, 1999).

Women's health services, family planning, safe childbirth, Essential Obstetric Care (EOC), referral services, and postpartum care are all offered under the current service (Bangladesh Demographic and Health Survey, 2004). Menstrual regulation (MR), preventing unintended pregnancies, treating abortion-related problems, post-abortion counseling, and information and counseling for clients in need of MR are all ways to prevent unsafe abortions (Akhter, 2000). The disparity in the services offered and activities carried out across different MCWC levels can be attributed to the current state of resources, including skilled labor, physical infrastructure, logistical support, etc. Reproductive health services are provided by technical staff, such as two-family welfare visits and two medical officers (Bhuiya et al., 2004).

In July 1998, the government launched the Health and Population Sector Programs (HPSP) with the goal of enhancing population reproductive health (Bangladesh Demographic and Health Survey, 2004). The program's primary goals are to lower the rates of maternal and infant death, infectious diseases, undesired pregnancies, and overall fertility, increase life expectancy, the age at which a woman gives birth to her first child, improve nutritional status, promote a healthy lifestyle, and provide family planning and health services to Bangladesh's underprivileged rural population (Bangladesh Demographic and Health Survey, 2004). The primary goals of the programs are to develop community clinics, essential service packages, union health and family welfare centers, union health centers, and support services. They also aim to promote a sector-wide management style (Bhuiya et al., 2004).

Despite the fact that there are currently 3,175 UHFWCs in the nation, 13,500 setup and 775 new UHFWCs will be built under HPSP (Bangladesh Demographic and Health Survey, 2004). Every 6000 people will have access to a single clinic. Activities related to Behavior Change Communication will also be reinforced in order to promote greater comprehension and bring about changes in attitudes (Bhuiya et al., 2000). Young women's demands in terms of reproductive health differ greatly from those of young males, mostly due to their younger age at marriage (Punitha, 2010). The World Health Organization states that, globally, women in their twenties have a five-fold lower risk of dying during childbirth than do girls under the age of 18 (WHO, 2011). The majority of female adolescents deal with the effects of early marriage, childbearing, inadequate schooling, and the threat of reproductive health issues, including HIV/AIDS and other STIs, as a result of inadequate information, education, and training about reproductive health issues (Rob et al., 2009). It stops different sexually transmitted infections from spreading (STDs) (ICDDRB, 2004). The birth of healthy children will be aided by appropriate medication and examinations. Increased sex education and awareness contribute to population maintenance and assist avert population explosion. Unwanted births are prevented. The use of contraceptives to prevent unintended births has been linked to women's health development (Bhuiya, I et al., 2000). The family's income has increased as a result of awareness of the benefits of having small families through the use of contraception (ICDDRB, 2004). Therefore, the study under this topic is very justified, as it allows us to understand the amount of knowledge, attitude, and practice that teenage girls have regarding reproductive health issues.

Objectives

The specific objectives of the study were- Firstly, to evaluate the knowledge, attitudes, and practices of rural adolescent females in the research areas about reproductive health issues. Secondly, to assess the socio-demographic features of sample rural adolescent females of the study areas and thirdly, to explore the level of knowledge and awareness to demonstrate the role of the information and education (media, counseling, services) facilities and family planning status in the management of reproductive health issues.

Review of Literatures

Adolescent reproductive health (ARH) remains a critical area of concern globally, particularly in countries like Bangladesh where access to reproductive health services and awareness among teenagers are limited (WHO, 2011; BBS, 2018). Understanding the challenges faced by adolescents in accessing reproductive health services and information is crucial for developing effective interventions to address their needs (Akhter, 2000). The study highlights several key themes within the field of adolescent reproductive health in Bangladesh: Limited access to reproductive health services for unmarried adolescents (Nahar, 1999; Population Council, 2004). Lack of awareness about puberty, menstruation, sexually transmitted infections (STIs), and HIV/AIDS among teenagers (Rob, 2001; Haider, 1997). Influence of family, peers, and societal factors on adolescents' reproductive health behaviors (UNFPA Bangladesh, 2005). Challenges faced by blind adolescents in maintaining menstrual hygiene (Punitha, 2010). Prevalence of early pregnancy and undernutrition among female adolescents (Field, 2004). Importance of timely access to HIV care and treatment for women (Patidar, 2010). The study explores the significant gaps in adolescent reproductive health knowledge and services in Bangladesh. Nahar's study (1999) and the Family Planning Association of Bangladesh's (FPAB) report (2020) reveal the persistent lack of awareness among teenagers about reproductive health issues (menstruation, the consequences of unprotected sex, STIs, HIV/AIDS transmission, menstrual regulation, and the availability of STI treatment facilities) (Nahar, 1999; Barkat, A., & Majid, M.,2003; FPAB, 2020). Additionally, research by Rob (2001) and

Haider (1997) demonstrates the inadequate knowledge of puberty-related changes and sexually transmitted infections among adolescents, especially concerning symptoms and prevention methods. Premarital sex, low condom use, and limited awareness of emergency obstetric care among married adolescents are highlighted by various studies (Bosch, A. M., 2005). The role of family, particularly parents, in shaping adolescents' reproductive health knowledge and behaviors is evident, as shown by the contrast in discussions with mothers versus fathers (Bhuiya et al., 2009). Peers, teachers, and community leaders are also influential but may act as barriers to adolescents exercising their reproductive health rights (ICDDRB, 2004). Punitha's study (2010) emphasizes the challenges faced by blind adolescents in menstrual hygiene management, indicating the need for targeted education and support. Moreover, the prevalence of early pregnancy and undernutrition among female adolescents underscores the urgent need for comprehensive reproductive health education and services. The societal preference for sons and low status of women further compounds these challenges. Patidar's (2010) research underscores the importance of timely access to care and treatment for both men and women living with HIV. The study highlights the beneficial effects of regular HIV testing and ongoing medical and gynecological care in promoting longer and healthier lives for individuals affected by the virus. By emphasizing the significance of comprehensive healthcare interventions, this research contributes to the understanding of gender-specific factors in HIV management.

In contrast, a significant portion of girls (68%) reported discussing such matters with their mothers, compared to only 30% of boys. A considerable number of adolescents (48% of girls and 58% of boys) received RH information from sources other than their parents or guardians. Girls were more likely to receive RH information from non-parental family members (64% compared to 6%), while almost all boys (96%) and half of the girls (45%) obtained information from friends. A recent study conducted by the Family Planning Association of Bangladesh (FPAB) in 2020 revealed that a substantial proportion of adolescents lack knowledge about menstruation, the consequences of unprotected sex, STIs, HIV/AIDS transmission, menstrual regulation, and the availability of STI treatment facilities. Kakavoulis and Forrest (2004) cross-cultural study delve into the complexities of attitudes and values surrounding sexual behavior and sex education among university students in different cultural contexts. The findings reveal variations in perceptions across societies while also identifying areas of convergence on certain issues. This study underscores the importance of considering cultural nuances in designing effective sexual health interventions, thereby enriching the discourse on culturally sensitive approaches to sexual education and health promotion. Garzón-Orjuela et al (2021) investigated into the effectiveness of sex education programs offers valuable insights into the role of education in mitigating risky sexual behaviors among teenagers. By demonstrating the positive impact of sex education in delaying sexual debut and promoting contraceptive use, particularly among high-risk populations, this study highlights the potential of preventive interventions in reducing the incidence of STIs and unplanned pregnancies. These findings underscore the importance of targeted educational initiatives in fostering informed decision-making and empowering individuals to protect their sexual health.

Building upon the foundation laid by previous research, this study aims to further explore the intersection of gender, cultural factors, and sexual health outcomes. By synthesizing insights from studies such as Patidar (2010) investigation into HIV management in women, Kakavoulis, and Forrest, (2004)) cross-cultural analysis of sexual attitudes, and Garzón-Orjuela et al (2021) research on sex education efficacy, this study seeks to identify gaps in current knowledge and propose novel approaches to address evolving challenges in sexual and reproductive health. Through empirical investigation and analysis, this study aims to contribute to the development

of evidence-based interventions that promote holistic well-being and equitable access to sexual healthcare services.

The study highlights the pervasive gaps and challenges in adolescent reproductive health in Bangladesh. It underscores the critical need for comprehensive sex education, accessible reproductive health services, and targeted interventions to address the specific needs of adolescents, especially girls and those with disabilities (WHO, UNFPA, UNHCR, 1997; Punitha, 2010). By contextualizing the existing literature, the discussion sets the stage for the current study, which aims to evaluate the knowledge, attitudes, and practices of rural adolescent females in the research areas about reproductive health issues and contributes to filling the identified gaps by providing insight into the knowledge, attitudes, and practices regarding reproductive health issues, including menstruation and family planning. By identifying socio-demographic features and sources of information, the study sheds light on the effectiveness of existing educational and healthcare services. This research has the potential to influence policy and interventions aimed at improving reproductive health outcomes among rural adolescents by highlighting areas where education and healthcare delivery can be enhanced.

In conclusion, adolescents in Bangladesh face various operational barriers in accessing accurate information about reproductive health and life skills, as well as quality reproductive health services and counseling. These barriers can be categorized into physical access barriers, psychological and social barriers, and quality barriers, affecting all adolescents regardless of marital status, gender, or school attendance.

Methodology

Study design:

This is the descriptive cross-sectional study designed to collect quantitative information on practice of reproductive health care facilities and family planning decisions of the rural adolescent females on Fulbari and Baiguni villages of Sariakandi upazilla of Bogura district. Quantitative data was collected through structured questionnaire.

Target site and population:

It is known that more than 23 percent of the total populations of Bangladesh are adolescents. Nearly half of them are girls aged between 10-19 years. For this study, girls aged between 14-19 years were included; as it seems that the girls aged less than 14 years are too young to responds the pre-selected question.

Study area and period:

It was detected that Fulbari and Baiguni villages of Bogura district under Rajshahi division taken as the study area or study site. Data was collected during the period January 2022 to June 2022

Sampling size:

Through multistage randomization sampling technique 75 adolescent females from each village were interviewed and data were collected from them.

Inclusion criteria:

1. Unmarried female adolescent who age 14-19 years was included in the study.
2. At least six months living in the village.
3. Study objects was free from mental and chronic diseases.

Exclusion criteria:
1. Refusal to given consent.
2. Below 14 years and above 19 years will be excluded.
3. Mentally handicap and retarded.
4. Those who do not want to cooperate with the interviewer during the interview.

Sampling technique:
The selection of rural adolescent females were obtained randomly and purposively. Multi stage randomization sampling technique was followed for the identification of sample population. Fulbari and Baiguni villages of Bogura district were selected for sampling considering the communication recompenses. Finally total 150 rural adolescent females of age between 14-19 years were interviewed and collected data from them.

Data collection:
For this study a detailed questionnaire in bangle were developed for collection of information from the unmarried adolescent girls. The interviewer's and supervisors were trained on the technique of collection of information and the details of the questionnaire. After incorporating the pretest findings and finalizing the questionnaire, the interviewers and supervisors were trained for collection of data. A total of 150 in-depth interviews were completed and information was collected from them. In each selected village of the upazilla, first the interviewers were identified randomly 75 adolescent girls of aged between 12 - 19 years. Asked the girls and obtain consent for the interview. When the girls were agreed then again asked her guardians for their consent of this interview. If any one of them, either the girls or guardians refused to give consent for interview, the interviewers were find another adolescent girl from the same or from the other ward within the same village of the upazilla. For collection of information through in-depth interview using questionnaires, the interviewer was collected information.

Data management and analysis plan:
All interview questionnaires were checked for their internal consistency, to exclude missing or inconsistent data. Data was entered into the data file using statistical software called W Stata.
The analytical plan of the study includes description of the study population by their socio-demographic characteristics first. For this, some descriptive statistics was used like mean, median, mode and percentages in order to find out the association between the dependent and independent variables, chi-square tests were performed to find out the bivariate relationship and their level of significance. For better view of the study population some graph and charts were used. Analysis was accomplished by the research team using W Stata. To adjust confounding effect multiple linear regression was done.

Quality control and quality assurance:
In order to ensure the utmost quality, interview was done by the researcher herself and her trained associates. Everyday filled up questionnaire were checked to exclude any gross mistake. Double entry of data were ensured to ensure accuracy.

Results and Discussion
The present study is based on primary data collection and in-depth interviews of 150 adolescent females at Fulbari and Baiguni villages of Sariakandi upazilla of Bogura district. Data collection was carried out by a group of trained interviewers through a structured questionnaire.

1.1 Age composition of the study population

The total population of the survey was 150 adolescent females. The mean age was 16.2 years. With regard to age composition of the survey population, it is observed that the highest concentration of the population was in age group 16-17 years which was 50% and second highest is in age group 18-19years which is 30%. It is interesting to note that the population composition in lower age group (14-15 years).

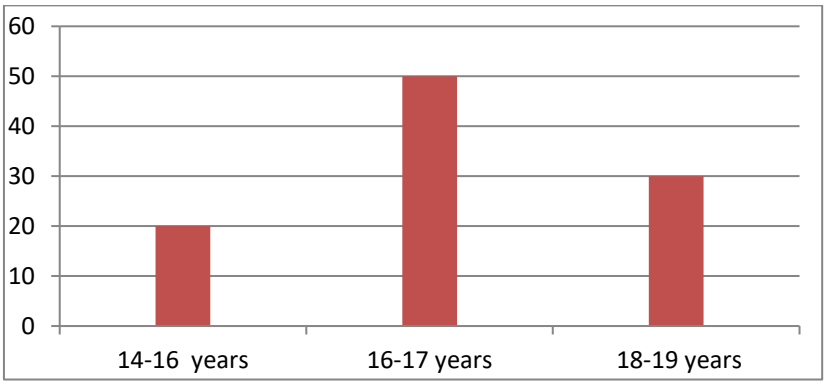

Figure 1.1: Distribution of surveys population by age group (n-150)

1.2 Educational distribution of the population

Education is expected to enhance the management of reproductive health, to restrain fertility, increase contraceptives use, reduce maternal and infant mortality etc. Also the increased education and employment opportunities for women will lead to more congenial gender roles and reduce the incidence of complications.

Table 1.1 Distribution of population by Schooling status and level of Education

Schooling status			Level of education		
Indicator	observation	percent	Class	observation	percent
Never Attend School	12	8.0	0	12	8.0
Currently in School	60	40.0	1-4	69	46.0
Drop Out	78	52.0	5-8	48	32.0
Total	150	100	9-10+	21	14.0
			Total	150	100

As primary level of education is considered as compulsory and marked as universal primary education for all in Bangladesh, the table above shows depressing picture of education. It shows only 46 % of adolescent has completing the level 5 and rest 54 % were fail to obtain the level 5. The table also shows 8 % of adolescent were never attend any school where 46 % attending level 1-4, 32 % attending level 6-8 and only 14% of adolescent were now completing level 8 and currently studying level 9 and above. It may be mentioned here that only 2 out of all 150 are now attending college and studying intermediate level.

1.3. Family size distribution of the respondents

Table 1.2 Distribution of the respondents according to their Family size

Family size	**HH respondents**		**Mean**	**SD**
	Number	%		
Small (1-4)	21	35	1.87	0.747
Medium (5-6)	26	43.3		
Large (above 7)	13	21.7		
Total	60	100		

Family size of the respondents of the study area ranged from 1 to above 7 persons, with an average of 1.87 persons and standard deviation 0.747. Respondents were classified into three categories because of their family size.

1.4 Distribution of population watching TV program

Now a day even in rural Bangladesh, the television proved its strength to connecting people to its different awareness programs. Peoples like this media to watch and learn through amusement. This study examines the current situation of watching TV program among the population. Though the rural family has little ability to purchase TV by own but their watching ability was not limited for that at least in compare to other media.

Table 1.3 Distribution of TV watching population by frequency

Exposure	Regularity	Percentage
Yes	Daily	50
	Weekly	22
	Bi-weekly	02
	Irregular	08
No		18

Total 82 % of the study population were had access and watching TV either regularly or irregularly. Among all respondent 72 %was watching TV program daily or weekly of which 50 % were watching daily and 22% were weekly. Only 18 % were had no access to the TV program.

1.5 Distribution of population by type of program watching TV program

When identified the population by type of TV program they had watching, the following were the results of that search. Highest 92.68 % of the populations were Watching cinema and 70.73% were to watch drama. These two are most interesting program to watch by them. 39.02% of them were watching news and 21.95 % were to watch songs. On the other hand only 4.87 % of the study populations were watching family planning program and 12.19 % of them to health education program.

Table 1.4 Distribution of population by type of Program watching in TV

Program type	Percent
News	39.02
Drama Cinema	70.73
Songs	92.68
Debate	21.95
Health education	7.31
Family planning program	12.19
Advertisement	4.87
Others (Magazine program	14.63

*Multiple Responses

Besides, 14.63 % were watching magazine program in the TV. Access or involvement in socio-cultural functions Involvement in social and cultural functions and activities in the community can be played good roles to change the attitude, knowledge and practice of any individuals.

1.6 Reproductive Health Knowledge and Practice

1.6.1 Knowledge on first menstruation

This study asked the respondents whether they know generally when and at what age a girl have started first menstruation. The table below describes their opinion on the issue. A significant high proportion 84 % thinks a girl staring her first menstruation at the age between 10 to 15 years of which 70 % starting at 10-12 years of age and 14 % are at age group of 13-15 years. 6% of respondents opinioned that first menstruation started at 7-9 years age group and

no one thinks that the first menstruation started at 15+ years of age. Among all 10 % of girls were not aware about the first menstruation of a girl's life.

Table 2.1 Distribution of knowledge on first menstruation starting age of girls

Age	Percent
7-9 years	6.0
10-12 years	70.0
13-15 years	14.0
15 + years	0.0
Don't Known	10.0
Total	100

1.6.2 Having first menstruations in life

The respondents were asked that whether their menstruation have started and what was their age at the time of their first menstruation. The following table shows that all of the respondents (150) were experiencing menstruation in the meantime. All of them have first menstruation between the ages of 10 to 15 years. 65.34% of the respondents having first menstruation in the age group of 13 to 15 years and rest 34.66% were in the age group of 10 to 12 years. No one have experiencing menstruation in the age group of 7 to 9 years or more than 15 years.

Table 2.2 Distribution of study population by Age of having first menstruations in life

Age	Percent	Observation
7-9 years	0.0	0
10-12 years	34.66	52
13-15 years	65.34	98
15 + years	0.0	0
Don't Known	0.0	0
Total	100	150

1.6.3 Knowledge on measures before 1St menstruation

Result shows in table 2.6a that highest 72.64 % of the study population's has no prior knowledge or idea about the management measures to be taken during menstruation. Only 27.33 % of the population has received information on measures tobe taken before their 1st menstruation from the different sources.

Table 2.3 Distribution of knowledge on measures to be taken before their 1st Menstruation

Response	Percent
Yes	27.33
No	72.64

1.6.4 Sources of knowledge on measures before 1st menstruation

The table below shows the sources of knowledge of the respondents from where they getting this information. Highest 70.71 % of the respondents were informed that they have received information on measures during menstruation from the members of the family. They are mothers (17.07 %), Sister (26.82 %), Cousin Sister (14.63 %) and Unties (12.19 %). School friends and non-school friends were the 2nd highest information provider to the adolescent female garment workers from outside of the family. 29.26 % of the respondents were having information from the non-school friends and 24.39 % of them were receiving this information from the school friends. The other two sources are neighbor who provides17.07 % and radio/TV provide 7.31 % of the respondents.

Table 2.4 Distribution of sources of knowledge on measures before 1st menstruation

Source	Percent
Friends	0
Mother	17.07
Grand mothers	0
Sister	26.82
Cousin sister	14.63
Unties	12.19
Neighbors	17.07
Health workers (Govt)	0
Health workers (NGO)	0
Teachers	0
Radio/TV	37.32
Doctors	0
Newspapers	0
Books	0
School friends	24.39
Sister in law	29.26

*Multiple Responses

1.6.5 Problems faced in seeking treatment

When basked the populations about whether they have faced or suffering from any problems during menstruation. The table 2.5 shows lower abdominal pain is the common complaint and highest 85.6 % of the populations were suffering from it. 37.96 % of the populations were suffering from Hip Joint Pain. Other common complain were excessive blood loss 11.5 %, loss of appetite 6.9 %, Irregular menstruation 4.6 %, having migraine 3.45 % and scanty blood loss 11.5% of the populations.

Table 2.5 Facing trouble/problems during menstruations by type of problems

Problems	Percent
Lower abdomen pain	85.6
Hip joint pain	37.96
Swelling between thigh	0.0
Irregular menstruation	4.6
Excess blood loss	11.5
Less blood loss	12.64
Loss of appetite	6.9
Vertigo	4.6
Headache	3.45
Other	1.15

*Multiple Responses

1.6.6 Knowledge about possible problems during menstruation

The table 2.6 describes knowledge of the population on the possible reproductive health problems in adolescence age. Out of 150 respondents 46 (30.66 %) explain that they have no idea about the problems of this age. Among the rest 104respondents 100 % reported in favor of lower abdominal pain. Besides, 39.42 % told about irregular and painful menstruation, 22.11 % for excessive blood loss, 11.53 %for abnormal menstruation and 2.88 % for pain/burning sensation during urination.

Table 2.6 Distribution of knowledge about possible problems during menstruation at adolescent age

Types of problems	Percent
Irregular/ painful menstruation	39.42
Abnormal menstruation	11.53
Lower abdomen pain	100
Excess blood loss	22.11
Menstruation with foul smell	0

Itching of vagina of girls	0
Problem during pregnancy	0
Problem during delivery	0
Problem after delivery	0
Contraception/Family planning	0
Pain/ burning during urination2	2.88
Don't Know	30.66

*Multiple Responses

1.6.7 Right age of marriage for Girls

The age of marriage is very important in reproductive health. When asked the populations about the right age of marriage for girls, the responses of the study population are showed in figure 1.2. The figure describes the results as 86.67 % of the population believes that the right age of marriage should be 18 to 20 years which is the highest. The 2nd highest is 5.33 % who believed that marriage should be at the age between 24-26 years of age and 4.67 % support for the age of 21-23 years of age. On the other hand, 3.33 % told that the right age of marriage should be 14 -17 years of age.

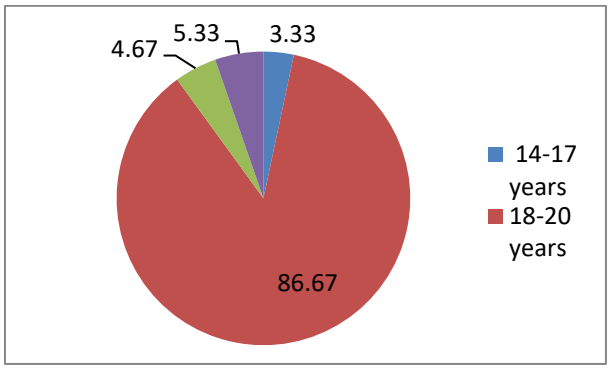

Figure 1.2 Opinion on right age of marriage for girls (n=150)

1.6.8 Right age of marriage for Boys:

The right ages of marriage for boys differ slightly from the girls. The same population has provide response in figure 2.106 where highest 44 % of girls believes that the right age of marriage for boys should be 21-23 years while 24 % (2nd highest)support for 24-26 years of age. 6 % of the populations are supporting 26+ years and only 2.67 % believes that it should be at the age of 14-17 years.

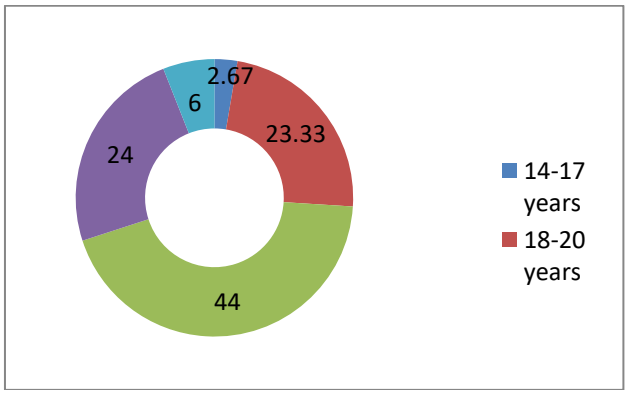

Figure 1.3 Opinion on right age of marriage for Boys (n=150)

1.6.9 Right age of girls to be a mother:

The right age of girls to become mother of first child is also important in reproductive health. Table 2.12 shows the results based on the opinion of the population. Highest 50 % of the

population stands for the age 19-21 years to become mother, 28 % believed that the right age to be a mother should be more than 21 years of age. Only 4 percent support for the age of 16-18 years and 18 % of the population has no idea about the right age of girls to be a mother.

Table 2.6 Distribution of opinions on right age of girls to be a mother

Category	Percent
16-18 Years	4
19-21 Years	50
21+ Years	28
Don't Know18	18

1.7 Family Planning

1.7.1 Hearing about family planning methods

According to table 2.7, 67% of the study population responded that they have hear about family planning methods. On the other hand 32.67 % replied that they did not hear about the family planning methods.

Table 2.7 Distribution of population hearing about family planning methods

Category	Percent
Yes	67.33
No	32.67

Table 2.8 Knowledge about different types of family planning methods

Methods	Percent
Condom	8
Oral pills	60
Injection	35.33
IUD (Copper T)	3.33
Implant/ Norplant	18.67
Female sterilization	12
Male sterilization	2
Safe periods	0
Absenting	0

*Multiple Responses

The Table 2.8 displayed the results of the knowledge about different family planning methods among the population who hear about family planning methods. 60% of the responded knows about oral pill and which the highest group in percentage. 35.33 % of them knew about injection, 18.67% knows about Implant/Norplant, 12% about Female Sterilization. 8 % aware about Condom and only 2 % knew about Male Sterilization.

1.7.2 Sources of information and places of availability of contraceptives on family planning

Table 2.9 describes that 32.67 % gets information on family planning from the TV and 6.67 % were from the Radio. 20.67 % were getting information from their relatives while 18 % from their friends. Only 10 % of the population received information about family planning methods from the govt. health worker and 2% from their sister-in-law (Bhabi). Table 2.10 shows the opinions of the population who knew family planning about the place of availability of contraceptives. Highest 58.41 % of the population replied that the contraceptives are available at clinic / hospital and 35.64 % knew that available in pharmacy. 25.74% replied, it is available with health worker and 10.89%responded find it at the grocery shop.

Table 2.9 Distribution of population by sources of information about family planning Methods

Sources	Percent
Radio	6.67
TV	32.67
Poster/ Billboard	0
Friends/ Neighbor	28
Relatives	20.67
Health worker (Govt.)	10
Health worker (NGO)	0
FWV	0
Sister-in-law (Bhabi)	2

*Multiple Responses

Table 2.10 Knowledge of the population about place of availability of contraceptives

Places	Percent
Clinic/ Hospital	58.41
Health Worker	25.74
Pharmacy	35.64
Grocery Shop	10.89
Others	3.96

*Multiple Responses

1.8 Health center by type

When asked the respondents about the type of the health center, the table 2.11 describes their responses. 45 % of the respondents knew that as UH&FWC/FWC and 31 1 % understand that center as an EPI center. 19 % of the respondents replied that the health center is NGO clinic and 18 % known the health center as Upazilla health complex (UHC). 17% of them are responds it as pharmacy, 13 % as private clinic and3% knows as the NGO satellite clinic.

Table 2.11 Distribution of health center by type

Type of Health Center	Percent
UH&FWC/ FWC	45
NGO Clinic	19
NGO Satellite Clinic	3
UHC	18
Sadar/ General Hospital	0
Private Clinic	13
EPI Center	31
Pharmacy	17
Others- (RAMP)	7

*Multiple Responses

1.9 Attitude and practice of service providers

Only 18 respondents were visited the health care center to obtain services. This research further investigated about the attitude and practice of the service providers while they have providing services. Table 2.12 describes the service provider's attitude. Behavior and practice towards clients. 60.01% were welcomed, 65.60% said that they have showing interest on them and 57.66 % replied no one were in the same room where they received treatment. Besides, 84.45% claimed for not maintaining privacy during giving services and not taking consent for examination. 90 % of them were claim against not using separate room for examination, 83.74% claimed not explaining any things, not using pictorials for making understanding, 79.20% reported about not share follow up time and places and also do not refer any client (89.81%).

Table 2.12 Distribution of response of the population by Attitude and practice of service providers during providing health care

Attitude/ Practice of service	Response	
	Yes (Percent)	No (Percent)
Welcomed	60.01	39.99
Showing interest	65.60	34.40
Is the any other client or people present in room	42.44	57.66
Service provider examine you	21.11	78.29
Maintains your privacy	15.55	84.45
Use separation room for examination	10	90
Taking consent before examination	5.55	94.45
Service provider explain to you	16.25	83.75
Use poster, leaflets, picture, chart during your service	0	100
Inform you when & where you come for follow up	21.80	79.20
Refer you to any other place	10.19	89.81

*Multiple Responses

1.10 Satisfaction on health care service:

Figure 2.1 showed the status of satisfaction of the client after receiving the health care services. Most of the respondents (83.33%) were not satisfied while only 16.67% express their satisfaction on the health care services.

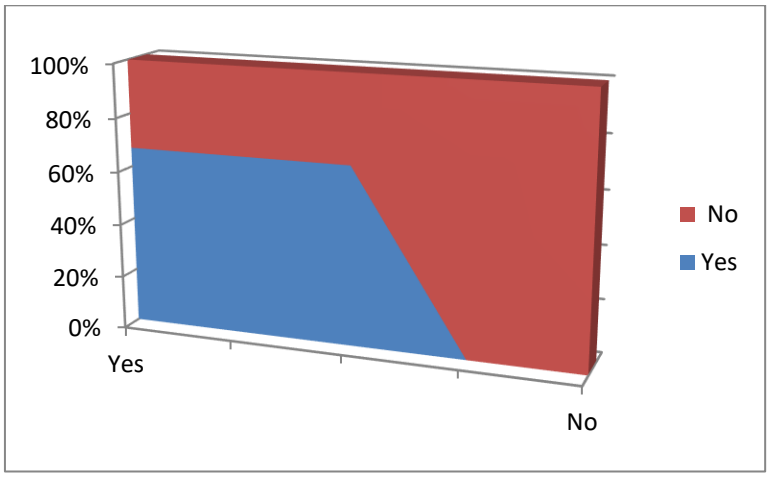

Figure 1.4 Distribution of population by level of Satisfaction on health care service received

Conclusion and Recommendations

The research explores that adolescent females possess inadequate knowledge regarding various reproductive health issues, including significant misconceptions about menstruation management. Additionally, there is a notable disparity between their knowledge, attitudes, and behaviors. Thus, it is imperative to develop a mechanism to enhance adolescents' understanding and translate it into practical application. The involvement of parents, guardians, teachers, religious leaders, and community influencers, who serve as primary gatekeepers, often poses significant barriers to addressing reproductive health issues among adolescent females. Without their wholehearted support and engagement, working with adolescent females becomes exceedingly challenging. Therefore, strategies must be devised to foster positive changes in the attitudes and behaviors of these gatekeepers. Furthermore, besides the provision of appropriate information, ensuring easily accessible reproductive health services for adolescents emerges as another critical necessity. While married adolescents may have some access to such services, unmarried individuals encountering reproductive health problems often face limited options. Ensuring optimal standards of care

across all service outlets is crucial for meeting the needs of adolescent females. The utilization of services, including information dissemination and treatments, through adolescent-friendly centers largely hinges on the knowledge and perspectives of both adolescents and their guardians regarding the existence and efficacy of such centers. Hence, targeted strategies are needed to reach both gatekeepers and adolescent females, emphasizing the importance of their well-being and encouraging their active participation. The study has delved deeper into the role of parents, guardians, teachers, religious leaders, and community influencers as primary gatekeepers, revealing the substantial barriers they pose to addressing reproductive health challenges among adolescent females. By emphasizing the importance of optimal standards of care across all service outlets, this study offers a tangible roadmap for policymakers and healthcare providers to improve service delivery and meet the diverse needs of adolescent females. By elucidating the factors influencing adolescents' and guardians' awareness and perceptions of these centers, the research lays the groundwork for targeted interventions aimed at increasing their uptake and effectiveness. This provides actionable insights for improving service utilization and ultimately enhancing adolescent reproductive health outcomes. The study represents a substantial advancement in our understanding of adolescent reproductive health in Bangladesh. By identifying key challenges and proposing targeted strategies for addressing them, the research offers a comprehensive framework for improving adolescent reproductive health outcomes and fostering a supportive environment conducive to positive behavior change. Given the dire circumstances facing adolescent females and the prevailing socio-cultural conservatism in the nation, the following recommendations are proposed: Encourage and provide training for gatekeepers, both formal and informal community leaders, as well as religious figures, across all levels, on Adolescent Reproductive Health (ARH) and gender-related issues. Establish an efficient referral system to facilitate access to necessary services. Conduct specialized training sessions for adolescent boys and girls at various healthcare facilities such as community clinics, satellite clinics, family welfare centers, and Upazila health complexes. Foster increased collaboration and networking among relevant government agencies and non-governmental organizations (NGOs) working with adolescents to ensure effective policy implementation. Deploy female doctors specifically for providing ARH services to adolescent females, enhancing accessibility and comfort in seeking healthcare. Develop and disseminate Behavior Change Communication (BCC) materials and Information, Education, and Communication (IEC) resources in collaboration with multicultural agencies to address cultural sensitivities. Encourage the formation of support groups for hard-to-reach, out-of-school adolescent females, facilitating the provision of information and guidance by both formal and informal leaders. Implement innovative strategies to address culturally sensitive ARH issues, focusing on building trust and desensitizing cultural gatekeepers such as mothers, sisters-in-law, parents, grandparents, village and community leaders, council chiefs, and religious or opinion leaders.

References

Akhter, H. H., Hossain, M. M., Mohsena Akter, S. N., & Rahman, H. (2000). *Report on needs assessment on reproductive health information and care among adolescents in paurashava school and college*. BIRPERHT. December. Population council, 2004. Status of married Adolescent in Bangladesh.

Bangladesh Bureau of Statistics (2018). Government of the People's Republic of Bangladesh.

Bhuiya, I., Rob, U., Chowdhury, A. H., Rahman, L., Haque, N., Adamchak, S. E., ... & Khan, M. E. (2004). *Improving adolescent reproductive health in Bangladesh*. Bangladesh Demographic and Health Survey 2004.

Bosch, A. M. (2005). *Adolescents' reproductive health in rural Bangladesh: the impact of early childhood nutritional anthropometry*. Rozenberg Publishers.

Barkat, A., & Majid, M. (2003). in BANGLADESH.

FPAB (2020), http://www.policyproject.com/pubs/countryreports/ARH_Bangladesh.pdf

Kakavoulis, A. (2001). Family and sex education: a survey of parental attitudes. Sex Education, 1(2), 163-174.

Nahar (1999). Improving *Adolescents Reproductive Health in Bangladesh*. Population Council and Frontiers in Reproductive Health. Bangladesh Demographic and Health Survey 1999.

UNFPA, Bangladesh (2005). *End line Survey report on Adolescents Reproductive Health.* https://bangladesh.unfpa.org/en July-11,2005.

Punitha (2010). *Adolescent's reproductive health status related to contemporary factors, with special emphasis on gender differences in Bangladesh*. ICDDRB.

Patidar, D., & Patidar, R. (2019). *A Descriptive Study to assess the knowledge regarding Domestic Waste Management and its, effect on Health among Home Makers from selected Rural Area of Mehsana District*. International Journal of Nursing Education and Research, 7(4), 581-583.

ICDDRB (2004). *Evaluation of a school based sexual and reproductive health education intervention among adolescent in rural Bangladesh*. WP 160.

Field, E. (2004). Consequences of Early Marriage for women in Bangladesh. draft, October,< efield@ latte. harvard. edu.

Garzón-Orjuela, N., Samacá-Samacá, D., Moreno-Chaparro, J., Ballesteros-Cabrera, M. D. P., & Eslava-Schmalbach, J. (2021). *Effectiveness of sex education interventions in adolescents: An overview*. Comprehensive child and adolescent nursing, 44(1), 15-48.

Thapar, N., & Sanderson, I. R. (2004). Diarrhoea in children: an interface between developing and developed countries. The Lancet, 363(9409), 641-653.

U.N. Doc. (1999). *Concluding Observations of the Committee on the Rights of the Child. Belize*, CRC/C/15/Add.99, at para. 25. 423 Id.

U.N. Doc. (1995) *Concluding observations of the committee on the Elimination of Discrimination against Women*. Chile, A/50/38, at para. 138.

World Health Organization. (1997). *Trends in maternal mortality: 1990-2015: estimates from WHO, UNHCR, UNFPA, world bank group and the United Nations population division*. World Health Organization.

World Health Organization. (1997). *Reproductive health indicators for global monitoring: report of an interagency technical meeting*, 9-11 April 1997 (No. WHO/RHT/HRP/97.27). World Health Organization.

World Health Organization. (2011). *Strategic directions for improving adolescent health in South-East Asia Region* (No. SEA-CAH-04). WHO Regional Office for South-East Asia.

Cite this article:

A.N.H Angona, A.T.M. Rezaul Hoque, & Md. Ahsan Habib (2024). A Study on Practice of Reproductive Health Care Facilities and Family Planning Decisions of the Rural Adolescent in an area of Bogura District, Bangladesh. *International Journal of Science and Business, 35*(1), 96-111. DOI: https://doi.org/10.58970/IJSB.2358

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