Adolescents Reproductive Health Care Needs and Factors: The Context of Bangladesh

Pinki Datta[1], Saraban Tahora[2], Aysha Akter[3]

ABSTRACT: Bangladesh is the seven most populated country in the world and close to one fourth of the total populations are adolescents. One in every five persons on the earth is an adolescent and 85 percents of these adolescents live in developing country. The study provided information to assist in the tracking of progress, the evaluation of the impact of the Health, Nutrition and Population Sector Program intervention. The main objective of the study is to investigate the health seeking behavior of the adolescents during the pregnancy and the factors which are influencing adolescent's reproductive health. The Bangladesh demographic and health survey 2004 interviewed 11440 ever married women under age 50 years where 1748 ever married women are adolescents and their median age is 17. The bivariate analysis and multivariate analysis (especially logistic regression model) were employed in analyzing data. The bivariate analysis suggests that demographic characteristics considered here are mostly statistically significant. Multivariate logistic regression analysis reveals that among the demographic factors number of living child, highest educational level, region, discussed family planning with husbands is statistically significant for current use of contraception, and number of living child, highest educational level and discussed family planning with husbands are statistically significant for desire for more children. In particularly, we identify sexual and reproductive health knowledge and attitudes for adolescents and assess utilization of reproductive health services among adolescents. This analysis of sexual reproductive health situation is necessary for successful implementation of health, nutrition and population sector strategy.

Keywords: Adolescents, Reproductive health, Sexual, Nutrition, Program, Population, Demographic, Family Planning, Contraceptive.

[1]   Lecturer, Department of Civil Engineering, UITS.
       * Corresponding author: Email: pinkijustat@yahoo.com
[2]   Assistant professor, Department of Civil Engineering, UITS.
       Email: sarabantahora@gmail.com
[3]   Assistant professor, Department of Civil Engineering, UITS.
       Email: aktera73@yahoo.com

1. INTRODUCTION

Today the world is facing the largest generation of adolescents ever in history. In the life cycle of a homespun organism, adolescence is a period of transition from childhood to adulthood to adulthood. It is characterized by rapid physical, biological and hormonal changes resulting in to psychological, behavioral and sexual maturation between the ages of 10-19 years in an individual [1]. Generally the persons whose ages are between 10-19 years called adolescents (Early adolescents 10-15; late adolescents 15-19). About 1.05 Billion adolescents live in the world. i.e. 60% of the total population in the world is adolescents [2]. Bangladesh is the seven most popular countries in the world and close to one fourth of the total populations are adolescents i.e. 23% populations are adolescents [3]. The number being approximately 36 million in the year 2001.Among them, about 8.8 million girls and 9.3 million boys fall in the age group of 10-14 years while 8.7 million girls and 9.5 million boys belong to the 15-19 years age group [3]. The annual growth rate of the adolescents population is 4.33%compared with 1.7% for the total population [4]. In recent years, adolescents reproductive health has become one of the most widely talked about and sensitive health issues among program planners around the world [2]. Adolescent's sexual and reproductive health refers to the physical and emotional well-being of adolescents and includes their ability to be healthy and remain free from too-early or unwanted pregnancy, unsafe abortion, sexually transmitted diseases including HIV/AIDS, and sexual violence or coercion.

Adolescent's health has been included as a part of essential services package and a separate program titled "Maternal Nutrition and adolescent's health" has been created to deal with the adolescent health issues. The description of Bangladeshi adolescent's reproductive health on the basis of information collected from two nationally representative surveys for married female adolescents [2]. The BDHS 1996-1997 indicated that about 36% of the teenage women have begun childbearing and among them 21% already mothers and 5% are pregnant with their first child [1]. A large proportion of the married female adolescents are unaware of the need for antenatal check-up during pregnancy, post natal care services, number of Tetanus Toxoid doses required for first pregnancy and throughout life, emergency obstetric care, emergency preparedness for delivery, and danger of performing abortion by untrained person. A substantial proportion of male adolescents and youths believe that mothers have a role in determining the gender of the child [5].

2. RESEARCH OBJECTIVES

The main objective of the study is to investigate the health seeking behavior of the adolescents. The specific objectives of the study are:

- To investigate the socio-economic and demographic characteristics of the adolescents.
- To investigate the knowledge and awareness of family planning methods and current use status.
- To investigate the desired fertility of the adolescents.
- To investigate the health seeking behavior of the adolescents during the pregnancy.
- To investigate the factors which are influencing adolescent's reproductive health.

3. DATA SOURCE AND METHIDOLOGY

The data for this study is from the 2004 BDHS, and was based on responses from a sample of women aged under 50. A total of 11440 ever married were interviewed of whom 1748 ever married women are adolescents. Details of the study design including questionnaire are to be found elsewhere [6]. Briefly, detailed information was collected concerning the demographic, socio economic characteristics of individual's respondents, their contraceptive use and desire for more children. Bivariate analysis and multivariate analysis (especially logistic regression model) were employed in analyzing data. To examine the effect of selected demographic, socioeconomic factors on the Adolescence reproductive health care needs, a logistic regression model was used. In this model the dependent variables are: current use of contraception and desire for more children.

The independents variables are: current age, number of living children, highest level of education, residence, region, wealth index, habit of reading newspaper, listing radio, watching Television, and discuss family planning with husband etc. A well-known statistical package named SPSS (Statistical Package for Social Science) Windows version 11.5 is used for the analysis. SPSS for windows is a comprehensive and flexible statistical analysis and data management system. SPSS can take data from almost any type of the file and use them to generate tabulated reports, charts and plots of distributions and trends, descriptive statistics and complex analysis.

4. DATA ANALYSIS AND FINDINGS

The bivariate analysis and multivariate analysis (especially logistic regression model) were employed in analyzing data. Statistically

describing the relationship between two variables at one time requires bivariate data analysis. We wish to test the differences and measuring the association between variables. In bivariate analysis, apply cross-tabulation technique for finding associated variable with others. Hence we test that two variables are associated or not.

The relation of the current use of contraception to selected variables classified as demographic and socio-economic are examined through the chi-square test. The p-values obtained through the test are compared to the level of significance.

Table 1: Association between current use of contraception and independent variables.

Variable		χ^2	d.f.	P-value
Demographic	Current Age	15.948**	4	0.003
	Number of living children	161.826***	2	0.000
Socio economic	Type of place of residence	4.510*	1	0.034
	Region	46.540***	5	0.000
	Highest educational level	30.831***	5	0.000
	Wealth index	18.852**	4	.001
	Habit of Reading newspaper	3.898*	1	.048
	Listing Radio	1.786	1	.181
	Watching TV	12.889***	1	.000
	Discussed family planning with Husband	341.942***	1	.000
	Desire for more children	7.855**	1	.005

*p<.05, **p<.01, ***p<.001

The Socioeconomic characteristics considered here are mostly statistically significant. i.e., region, highest educational level, watching Television, discussed family planning with husband, desire for more children, wealth index, habit of reading newspaper these variables effect are statistically significant for use of contraception. Among demographic variables significant relationship is found in current age, number of living children with use of contraception. Again listening Radio is not statistically significant with use of contraception.

The chi-square test provides a preliminary idea as to which variables have important affects on desire for more children. Now we give a brief description of the background characteristics of the variable and chi-square test to examine the association between desire for more children and independent variables.

Table 2: Association between desire for more children and independent variables.

Variable		χ^2	d.f.	P-value
Demographic	Current age	64.910***	4	.000
	Number of living children	189.435***	2	.000
Socioeconomic	Type of place of residence	.016	1	.900
	Region	2.231	5	.816
	Highest educational level	39.254***	5	.000
	Wealth index	4.088	4	.394
	Habit of Reading newspaper	8.147**	1	.004
	Listening Radio	12.081**	1	.001
	Watching TV	.120	1	.729
	Discussed family planning with Husband	22.401***	1	.000
	Current use of contraception	7.855**	1	.005

*p<.05, **P<.01, ***p<.001

Current age, number of living children all of these variables effect are statistically significant for desire for more children. Some of the socio-economic characteristics considered here are statistically significant. Highest educational level, discussed family planning with husband, listening radio and current use of contraception have significant relationship with desire for more children. Again type of place of

residence, region, wealth index, watching TV none of these effects are statistically significant with desire for more children.

5. FACTOR INFLUENCING ADOLESCENTS REPRODUCTIVE HEALTH

Here investigate and bring together the factors as identified in order to analyze and explain variations of their relative effect on use of contraception and desire for more children in measured form. When we examine each independent variable individually, it can only provide a preliminary idea of how important each variable is by itself. So the relative importance of all the variables has to be examined simultaneously by some multivariate methods. There are a variety of multivariate statistical techniques that can be used to predict a binary dependent variable from a set of independent variables. Logistic regression techniques were used to find the factor which influencing adolescent reproductive health.

Let Y_i represents a dichotomous variable that equals 1 if the respondent use contraception and 0 if the respondent do not use contraception. The probability of using contraception, $\Pr(Y_i=1)$, is the cumulative density function F evaluated at $X_i\beta$ where X_i is a vector of independent variables and β is a vector of unknown parameters. This kind of probability function has the following form

$$P_i(Y_i = 1) = \frac{\exp(X_i\beta)}{1 + \exp(X_i\beta)}$$

The estimation from of the logistic transformation of the probability of using contraception,

Pr ($Y_i = 1$) can be represented as

$$\ln\left[\frac{p_i}{1 - p_i}\right] = \beta_0 + \beta_1\beta x_1 + \beta_2 x_2 + \beta_3 x_3 + \dots + \beta_n x_n \quad (1)$$

In our case, the dichotomous dependent variable is

CUC = Current use of contraception

1 = Use of contraception

0 = Not use of contraception

The independent variables are

CAR = Current age of respondents

NLC = Number of living children
2+ = More than two children 1 = One children
0 = No children

HEL = Highest educational level
0 = Higher education
1 = Complete Secondary
2 = Incomplete Secondary
3 = Complete primary
4 = Incomplete primary
5 = No education

WI = Wealth Index
0 = Poorest
1 = poor
2 = middle
3 = Richer
4 = Richest

WTV = Watching TV
1 = yes
0= no

DFPH = Discussed about family planning with husband
1 = yes
0 = no

PR = Place of residence
0 = Rural
1 = Urban

DI = Division
0 =Sylhet
1 = Chittagong
2 = Barisal
3 = Dhaka
4 =Rajshahi
5 = Khulna

HRN = Habit of reading newspaper
1 = yes
0 = no

LR = Listening radio
1 = yes
0 = no

DMC = Desire for more children
1 = yes
0 = no

Now the equation (1) becomes

$$CUC = \ln\left[\frac{p_i}{1-p_i}\right]$$

$$=\beta_0+\beta_1(CAR)+\beta_2(NLC) + \beta_3(HEL) + \beta_4(PR) + \beta_5(DI) + \beta_6(WI)$$
$$+\beta_7(HRN)+\beta_8(LR)+\beta_9(WTV) + \beta_{10}(DMC) + \beta_{11} \text{ (DFPH)} \qquad (2)$$

Table 3 contains estimate of regression coefficients of Beta, Standard error of Beta, significance of Beta, odds ratio and 95% confidence interval for odds ratio.

Now, the regression coefficient is significant for number of living children. From (**table 3)** we see, the estimated odds ratio for the mothers who have one child is 0.23, which indicates that the use of contraception is 77% lower than the mothers who have 2 or more children. Again, the estimated odds ratio for the mothers who have no children is 0.19. i,e; the use of contraception is about 81% lower than the mothers who have 2 or more children. Level of education has significant effect on use of contraception.

Table 3: Logistic Regression to Determine the Factor affecting current Use of contraception.

Factor		Coefficient β	S.E. (β)	Sig. (β)	Odds ratio $[\exp.(\beta)]$	95% C.I. for $\exp(\beta)$	
						Lower	Upper
Current age	15(r)	……	……	……	1.000		
	16	.243	.235	.302	1.275	.804	2.022
	17	.077	.207	.709	1.080	.719	1.622
	18	.212	.187	.256	1.236	.857	1.782
	19	.277	.182	.128	1.319	.923	1.884
Number of Living Children	2+(r)	……	…..	…..	1.000		
	1	-1.492***	.248	.000	.225	.138	.366
	0	-1.650***	.149	.000	.192	.143	.257
Level of education	Higher(r)	…..	…..	…..	1.000		
	Complete Secondary	-.284*	.436	.023	.753	.158	.873
	Incomplete Secondary	-.399	.474	.399	.671	.265	1.698
	Complete Primary	-.467*	.213	.028	.627	.413	.951
	Incomplete Primary	-.631*	.258	.014	.532	.321	.882
	No education	-.991	.215	.185	.371	.194	1.146
Residence	Rural(r)	…..	…..	…..	1.000		
	Urban	.125	.177	.481	1.133	.801	1.602

Region	Sylhet(r)	……	……	……	1.000		
	Chittagong	1.463***	.387	.000	4.319	2.024	9.214
	Barisal	.923***	.232	.000	2.517	1.597	3.967
	Dhaka	.257	.300	.391	1.293	.719	2.326
	Rajshahi	.210	.211	.321	1.234	.815	1.868
	Khulna	-.021	.208	.920	.979	.651	1.473
Wealth index	Poorest(r)	…..	…..	……	1.000		
	Poor	.466*	.268	.017	1.596	1.122	3.203
	Middle	.684**	.243	.002	1.982	1.302	3.381
	Richer	.572	.230	.172	1.769	.872	2.151
	Richest	.639*	.228	.010	1.895	1.148	2.807
Habit of reading news paper	Yes(r)	……	……	…….	1.000		
	No	-.529	.171	.758	.589	.354	1.472
Listening Radio	Yes(r)	……	……	……	1.000		
	No	-.011	.137	.937	.989	.756	1.294
Watching TV	Yes(r)	……	…….	……	1.000		
	No	-.136	.145	.348	.873	.656	1.160
Desire for more Children	Yes(r)	……	……	……	1.000		
	No	.478*	.190	.010	1.613	.922	1.890
Discussed F.P. with husband	Yes(r)	…..	……	……	1.000		
	No	-1.952***	.129	.000	.142	.111	.183

Note: r =reference category   *p<.05, **p<.01, ***p<.001

The estimated odds ratio for the respondents who have completed secondary education is 0.75, which indicates that the use of contraception is 25% lower than the respondents who have higher education. Again, the estimated odds ratio for the respondents who have not completed secondary education is 0.67. i,e; the use of contraception is about 33% lower than the respondents who have higher education.

The estimated odds ratio for the respondents who have completed primary education is 0.63, which indicates that the use of contraception is 37% lower than the respondents who have higher education. Again, the estimated odds ratio for the respondents who have not completed primary education is 0.53. i,e; the use of contraception is about 47% lower than the

respondents who have higher education and the estimated odds ratio for the respondents who have no education is 0.37. i,e; the use of contraception is about 63% lower than the respondents who have higher education (table 3).

The regression coefficient is significant for wealth index. The estimated odds ratio for the respondents who are poor is 1.60, which indicates that the use of contraception is 60% higher than the respondents who are poorest. Again, the estimated odds ratio for the respondents who are middle is 1.98. i,e; the use of contraception is about 98% higher than the respondents who are poorest. The estimated odds ratio for the respondents who are richer is 1.77, which indicates that the use of contraception is 77% higher than the respondents who are poorest. Again, the estimated odds ratio for the respondents who are richest is 1.90 i,e; the use of contraception is about 90% higher than the respondents who are poorest (table 3).

Desire for more children has significant effect on use of contraception. The estimated odds ratio for the respondents who do not have desire for more children is 1.61, which indicates that the use of contraception is 61% higher than the respondents who have desire for more children (table 3).

The regression coefficient is significant for discussed family planning with husband. The estimated odds ratio for the respondents who have not discussed family planning with husband is 0.14, which indicates that the use of contraception is about 86% lower than the respondents who have discussed family planning with husband (table 3).

Table 4 represents logistic regression analysis, where the dependent variable is desire for more children. Here we consider the same independent variables that we consider for current use of contraception.

In our case, the dichotomous dependent variable is

DMC = Desire for more children

1 = have desire for more children

0 = do not have desire for more children

The estimation from of the logistic transformation of the probability of the desire for more children is Pr(Yi =1) can be represented as

$$DMC = \ln\left[\frac{p_i}{1 - p_i}\right]$$
$$= \beta_0 + \beta_1(CAR) + \beta_2(NLC) + \beta_3(HEL) + \beta_4(PR) + \beta_5(DI) + \beta_6(WI) + \beta_7(HRN) + \beta_8(LR) + \beta_9(WTV) + \beta_{10}(CUC) + \beta_{11}(DFPH)$$

Table 4 contains estimate of regression coefficients of Beta, Standard error of Beta, significance of Beta, odds ratio and 95% confidence interval for odds ratio.

Table 4: Logistic Regression to Determine the Factor affecting of desire for more children.

		Coefficient β	S.E. (β)	Sig. (β)	Odds ratio [exp.(β)]	95% C.I. for exp(β) Lower	Upper
Current age	15(r)	….	…..	….	1.000		
	16	-1.196**	.351	.001	.302	.152	.601
	17	-.497*	.251	.048	.608	.371	.996
	18	-.591**	.218	.007	.554	.361	.849
	19	.163	.191	.394	1.177	.809	1.710
Living Children	2+(r)	……	.….	….	1.000		
	1	.476**	.237	.001	1.610	1.412	4.978
	0	.636***	.183	.000	1.889	1.111	2.274
Highest level of education	Higher(r)	…..	……	……	1.000		
	Complete Secondary	.134	.725	.057	1.143	1.035	2.594
	Incomplete Secondary	.234*	.747	.046	1.264	1.061	1.142
	Complete Primary	.393**	.230	.001	1.482	1.307	1.756
	Incomplete Primary	.421**	.292	.001	1.523	1.295	1.927
	No education	.648***	.215	.000	1.912	1.599	2.390
Residence	Rural(r)	…….	…….	…….	1.000		
	Urban	.054	.207	.795	1.055	.703	1.584
Region	Sylhet(r)	…….	…….	……	1.000		
	Chittagong	-.467	.370	.206	.627	.304	1.294
	Barisal	-.737**	.271	.006	.479	.282	.814
	Dhaka	-.344	.366	.347	.709	.346	1.452
	Rajshahi	-.402	.245	.100	.669	.414	1.081
	Khulna	-.196	.241	.417	.822	.512	1.319
Wealth index	Poorest(r)	…..	……	……	1.000		
	Poor	-.373	.309	.228	.689	.376	1.262
	Middle	-.251	.290	.385	.778	.441	1.372
	Richer	-.368	.283	.193	.692	.397	1.205
	Richest	.014	.275	.961	1.014	.592	1.737

Habit of reading news paper	Yes(r)	……	…..	……	1.000		
	No	.631*	.224	.019	1.879	1.567	2.364
Listing Radio	Yes(r)	……	…….	……	1.000		
	No	.527*	.158	.021	1.694	1.509	1.946
Watching TV	Yes(r)	……	…….	……	1.000		
	No	.368*	.172	.033	1.445	1.030	2.026
Current use of contraception	Yes(r)	……	……	……	1.000		
	NO	.387*	.169	.02	1.473	1.339	1.858
Discussed F.P. with husband	Yes(r)	……	…….	…….	1.000		
	No	-.686***	.176	.000	.504	.357	.711

Note: r =reference category   *p<.05, **p<.01, ***p<.001

The regression coefficient is significant for number of living children. From (table 4) we see, the estimated odds ratio for the mothers who have one child is 1.61, which indicates that the desire for more children is 61% higher than the mothers who have 2 or more children. Again, the estimated odds ratio for the mothers who have no children is 1.89. i,e; the desire for more children is about 89% higher than the mothers who have 2 or more children.

Level of education has significant effect on desire for more children. The estimated odds ratio for the respondents who have completed secondary education is 1.14, which indicates that the desire for more children is 14% higher than the respondents who have higher education. Again, the estimated odds ratio for the respondents who have not completed secondary education is 1.26. i,e; the desire for more children is about 26% higher than the respondents who have higher education. The estimated odds ratio for the respondents who have completed primary education is 1.48, which indicates that the desire for more children is 48% higher than the respondents who have higher education. Again, the estimated odds ratio for the respondents who have not completed primary education is 1.52. i,e; the desire for more children is about 52% higher than the respondents who have higher education and the estimated odds ratio for the respondents who have no education is 1.91. i,e; the desire for more children is about 91% higher than the respondents who have higher education (table 4).

Level of education has significant effect on desire for more children. The estimated odds ratio for the respondents who have completed secondary

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6. DISCUSSION AND CONCLUSIONS

The study used the BDHS 2004 to assess utilization of reproductive health services among adolescents. Using available secondary data of Bangladesh Demographic and Health surveys (BDHSs), the study obtained the quantitative information while in-depth interview, case study and focus group discussions were done to obtain qualitative information on sexual and reproductive health of female adolescents (age 13-19 years).

Nearly one-fourth of the population fall in 15-19 years age group, which constitutes over 44 million in number –more than half of them females and 81 percent live in rural areas. The difference, however, has narrowed in the past ten years. Interestingly, improvement in education has been much rapid for women. Only one-third of adolescent in Bangladesh make the decision on their own or jointly with their husbands or someone else in the household.

Still one-fifth of women age 15-19 enter marriage their 16th birthday. The legal age at marriage in Bangladesh is 18 years for women; however a large proportion of marriages still take place before the legal age.

Since 1999-2000, there has been a decline in the age specific fertility rate for age 15-19, from 144 to 126 births per 1,000 women. While the age-specific fertility rates among young women have not changed much since 2004, examination of the level of pregnancy among teenagers shows that there has been a decline in the percentage of young women who have started childbearing.

The vast majority of girls in Bangladesh begin sexual activity during adolescence, mostly within the context of marriage. The adolescent

women were unknown about sexual activities. They have fear and very much ignorant about the process. Their knowledge is very much limited and guided by mother or grandmother restriction. There is increasing openness about sex and reproduction among the youth of Bangladesh thanks largely to the spread of television and other media in the past two decades. Most of the adolescents had some awareness of reproductive health, including information about puberty, childbirth and pregnancy-related problems. However, they also had many misconceptions, for example, about the fertile period during the menstrual cycle and about causes of infection. Underlying these was a lack of communication with parents and other responsible adults, e.g.; only one-third of mothers had discussed puberty with their daughters.

Reproductive health is not discussed in most families, and sex education is completely absent in schools. In the discussion the adolescents felt that there was great needed for reproductive health education. The inadequacy of information about sexual and reproductive health is exacerbated by a lack of services for adolescents, particularly the unmarried. Girls are particularly disadvantaged because their access to information is constrained. Nobody felt the necessity of having reproductive health services if they are unmarried. Even adolescents whose sexual and reproductive health needs are different and legitimized by marriage have inadequate access to services as their youth limits their autonomy to make decisions and move around freely.

The contraceptive prevalence rate among adolescent married women has increased from 25 percent in 1993-94 to 40 percent in 2004. This translates to more than 60 percent increase. This increase in the use of modern temporary methods is prominent but use of long them method shows a declining trend. However, use of permanent or long term method and traditional method declined. Majority of adolescent women are not using family planning method. The most common fertility related reason for non use is fatalistic, cited by 31 percent of non users. The fatalistic attitudes refer to believing that having children depends on God's will. Other major reasons for nonuse are opposition to family planning and method related reasons. Thirty percent of adolescent do not intend to use contraceptives because of opposition to family planning by themselves, their husband, or other or because of religious prohibitions. Sixty five percent of adolescent women with a birth in the five years preceding the survey received antenatal care at least once from a provider (trained or untrained) while 56 percent received care from a medically trained provider, that is , a doctor , nurse/midwife, community skilled birth attendant or medical assistant/sub-0assistant community medical officer.

7. RECOMMENDATIONS

The study results point to a number of actions that the health, nutrition and population sector program should consider in efforts to improve sexual and reproductive health of adolescents.

Focus on adoption and promotion: First of all, the program clearly must focus on promoting increased adoption among adolescents. Knowledge and availability of service information must be available for them. Efforts are also needed for promotion on the benefit of late marriage, sexuality, reproductive health, nutrition services. From the program standpoint, there are potential efficiencies in promoting the services among young women. This could be done focusing adolescents.

Improve motivation and follow up: The study findings suggest that there is a need to improve the motivating that woman to receive a reproductive health service from their provider, particularly on the problems, they may experience, and on appropriate responses if complications occur. In particular, providers should encourage young women to return for regular follow up care and for assistance if they have problems with services.

Target communication efforts: The findings indicate that there is a clear need to identify effective communication strategies to address the negative images many adolescents and especially their elders. Adolescents have clear needed and strategies are needed to address their necessity. The results also suggests that communication efforts for promoting positive attitudes about women's roles, especially in reproductive decision making are likely not only to improve women's status but also to contribute to increased use of reproductive health services.

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