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KNOWLEDGE, ATTITUDE AND PRACTICES ON REPRODUCTIVE HEALTH CARE AMONG RURAL ADOLESCENT FEMALES: A CROSS SECTIONAL STUDY ON CHINGUSPUR VILLAGE, BOGURA SADAR, UPAZILLA OF BANGLADESH

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ABSTRACT

Adolescent's reproductive health is a serious concern in Bangladesh. The present study was based on primary data of 150 rural adolescent females of Chinguspur village, Bogura Sadar, Upazilla of Bangladesh. Objectives of the study was to assess the socio-demographic features of sample rural adolescent females and to explore the level of knowledge and awareness to demonstrate the role of the information and education (media, counseling, services facilities) in the management of reproductive health issues. The mean age of the respondents was 16.2 years. The religion of the surveyed population were found 92% Muslim while 8% Hindu. A large number of rural adolescent females have been found to discontinue education after a few years of schooling. Only 14% girls are currently enrolling and reading in class nine or more. Most of the girls (36.33%) in the study population used pieces of old cloths/rags (nekra) as pads during menstruation, while some did not use anything. 39% of the rural adolescent females used rags that were wet or had not been dried in a hygienic fashion. Among all most of them were not known or received any information about the management of menstruation before their first menstruation. The study revealed that 72.41% of adolescents were suffering at least one complication or problems of menstruation, were not visited or seeking any consultation or treatment from any service providers available. Only 27.59% taken consultation from the service providers. While 41.66% go to traditional or herbal practitioners (locally called Kobiraj) but 33.33% visited to qualified doctors. The study indicated that the rural adolescent females of the study area poorly informed about most of the reproductive health issues. They have misconceptions regarding healthy management of menstruation and a big gap between their knowledge, attitude and practice.

Keywords: Knowledge, attitude, reproductive healthcare, adolescent, puberty

Introduction

Adolescents constitute one-fourth of the population of Bangladesh (Bhuiya *et al.* 2004). The term "Adolescent" is derived from the Latin word "ADOLESCERE" meaning to grow, to mature. Adolescent can be defined as the development period between childhood & adulthood-beginning with the changes associated with puberty & culminating in the acquisition of adult roles and responsibilities. An important implication for reproductive health programs is to ensure that the quality of services is improved, particularly from the user perspectives. The focus of the program is based on women since they are the primary users of these programs. Equal importance should be given to promote male responsibility and enhance their involvement.

Target groups for the reproductive healthcare services are women and men of different stages of life. Reproductive events in women's life can be divided in many parts such as: preconception, conception, childbirth, post-natal, interconnection, and premenopausal and infertility. In the ICPD (International on Population and Development) Conference in 1994 (held in Cairo) it was decided that for ensuring the reproductive health services, the service should include reproductive healthcare through Primary Healthcare System, family planning services, information education and counseling; management of side-effects of family planning methods; information services for pre and post-natal, safe delivery, breast feeding and women's healthcare; treatment of infertility and reproductive tract infections and prevention and management of unsafe abortion; diagnosis and treatment of sexually transmitted

diseases and information, education and counseling, as appropriate on human sexuality, reproductive health and responsible parenthood; diagnosis and treatment of breast cancer and cancer of the reproductive tract; prevention and increasing awareness about consequences of HIV.

The main purpose of the program is the reduction of maternal and child mortality, contaminated diseases, unwanted fertility and total fertility rate, enhancing of life expectancy, age of women at birth of first child and nutritional status and healthy life style and ensuring of health and family planning services to the underserved rural population of Bangladesh. The main strategy of the programs is to introduce sector-wide management approach, essential service package, building of union health and family welfare center, establishing of community clinics, and support services. Under HPSP there will be 13,500 set-up and 775 UHFWCs will be constructed in spite of existing 3,175 UHFWCs in the country. There will be one clinic for 6000 population. To foster better understanding and bring attitudinal changes, Behavior Change Communication activities will also be strengthened.

Thus successful implementation of HPSP will be an important element of Bangladesh's poverty reduction in three ways: *firstly* improvements in the health/family welfare status of the population are important indicators of poverty alleviation. They will increase the labor productivity and, thus, support the economic growth component of the poverty reduction strategy; *secondly* positive impact of HPSP will be through targeting the underserved population; and *thirdly* improvements in health/ family welfare status will be achieved more easily with respect to the legal status of women.

The government of Bangladesh has thus identified adolescent health and education both as a priority and a challenge and to face the challenge, has incorporated this issue in the current Health and Population Sector Program (HPSP, 1998–2003). There are expectations that with the introduction of the Essential Services Package (ESP) across Bangladesh through the HPSP, there will be an overall increase in the quantity and quality of information and services available for adolescents through a network of clinics at various levels: community, upazila, and district. However, studies conducted by the different agencies for improvements directly associated with HPSP service delivery are unlikely to make significant contributions to achieving ARH results during the HPSP period (1998- 2003) without additional efforts from other agencies. Keeping these in view the study was under taken to assess the socio demographic features, explore the level of knowledge of awareness and the role of information and amp; education (media, counseling services facilities) for the management of reproductive health issues of the adolescent female in rural area.

Methodology

Study design: This is the descriptive cross sectional study designed to collect quantitative information to assess the knowledge, attitude and practices on reproductive health issues among rural adolescent females on Chinguspur village, Bogura Sadar, Bogura. 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 the m 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 Chinguspur village of Bogura district under Rajshahi division taken as the study area or study site. Data was collected during the period January 2021 to June 2021

Sampling size: Through multistage randomization sampling technique 150 adolescent female 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 month living in the village.
3. Study objects was free from mental and chronic diseases.

Sampling technique: Rural adolescent females were selected purposively. Multi stage randomization sampling

technique was followed for the identification of sample population in Chinguspur village, Bogura Sadar, Bogura. Finally, 150 rural adolescent females of age between 14-19 years were interviewed for data collection.

Data collection: A questionnaire were developed for collection of data from the adolescent female. The interviewer's and supervisors were trained on the data collection as per questionnaire. After incorporating the pretest findings and finalizing the questionnaire, the interviewers and supervisors were trained. In each selected ward of the union first the interviewers were identified randomly ten adolescent females of 12 - 19 years from one village. Asked them and obtained consent for the interview. When they agreed then again asked her guardians for their consent of this interview. If any one refused to give consent for interviewed, the interviewers find another adolescent from the same or from the other villages within the same ward of the union. The interviewers was collected information as need based.

Statistical analysis: 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. 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 was performed to find out the bivariate relationship and their level of significance. To adjust confounding effect multiple linear regression was done.

Results and Discussion

The mean age was 16.2 years of the surveyed adolescent. It was observed that the highest concentration of the surveyed population was in age group of 16-17 years which reflected 50% but the second highest group 18-19 years of 30%. It was interesting to note that the population composition in lower age group was 14-15 years.

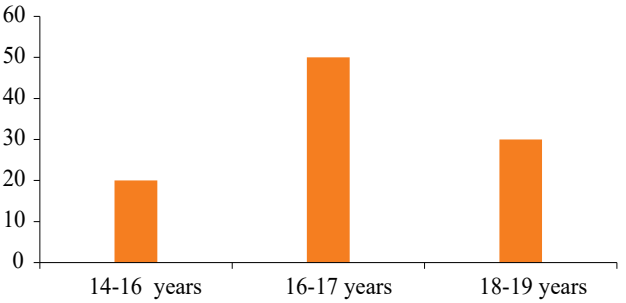


Figure 1. Distribution of surveys population by age group (n-150).

The religion of the surveyed population showed 92% of Muslim while Hindu 8%. No other adolescent were interviewed by the interviewer from any other religions. It is not exactly same distribution of national average of religions. Though there is population of other religion in the study area the interviewer may find it easy to contact with them to interview. Also may be they were not willing to talk about the issues.

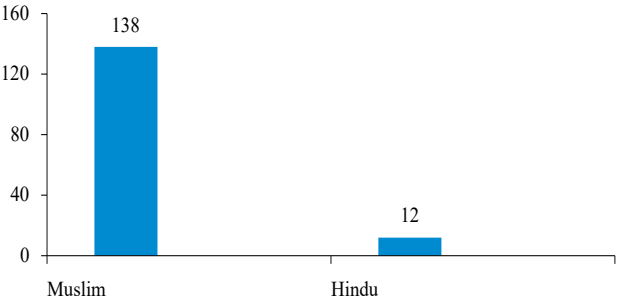


Figure 2. Distribution of religion of the surveyed population.

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. Primary level of education is considered as compulsory for all in Bangladesh but shows depressing picture of education (Table 1). Only 46% of adolescent has completing the level 5 and rest 54% were failed to obtain the level 5. The table also showed 8% of adolescent never attended any school where 46% attended level 1-4, 32% attended level 6-8 but only 14% were now completing level 8 and currently studying level 9 and above.

Reproductive Health Knowledge and Practice

Knowledge on first menstruation: This study asked the respondents whether they know generally when and at what age a girl have started first menstruation. 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. While 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.

Knowledge about healthy measures during menstruation: The knowledge about healthy measures should be taken during menstruation shows that 36.33% respondent opinioned in favor of use of old cloths and 15.66 % used clean and dry cloths but 13.33 % adolescent female garment workers use of Panty during menstruation. Besides 9.37% sued savlone/Dettol/soap. The researcher further asked to identify the sources of information they have taught which should be followed during menstruation. The results showing that, most of the information were obtained from the own family. 76.66 % of the information on the issue received from the closed family members especially mother (32.33%) and sisters (30.33%) also from other sources. Nair *et al.* (2013) reported that Majority of community stakeholders expressed that adolescents get knowledge regarding personal hygiene from their family itself and that they have poor knowledge about genital hygiene. Present results are comparable with that of (Alam *et al*. 2022). Sixty-five percent girls disagreed/strongly disagreed about feeling distracted or trouble concentrating in class at endline, compared to 41% at baseline during menstruation.

Sources of information on healthy measures during menstruations

First menstruations and problems faced: The respondents were asked that when their menstruation have started and what was their age at the time of their first menstruation. All of them answered that the first menstruation aged between 10 to 15 years (Table 3). Among them 65.34% respondents answered 13 to 15 years while rest 34.66% were at the age 10 to 12 years. Results revealed that all the respondents were faced and suffering from different types of problems. Lower abdominal pain is the common complaint and highest 46.6% of the populations. 23.96% respondents were suffering from Hip Joint Pain. Other common complain were excessive blood loss 8.5%, loss of appetite, Vertigo, Headache 6.64%, irregular menstruation 3.6%, and scanty blood loss 6.64%. Present results are parallel with Alam *et al.* (2022). They found that most girls received information from the closed family members.

Seeking treatments for problems of menstruations: The table 4 shows the types of service provides and available places of reproductive health services/treatments that seeking treatments from different type of service providers. Among them the highest 41.66% population were taking consultation/ treatment from the traditional Kobiraj while 33.33% taken treatment from qualified doctors. The place of availability of reproductive health services and treatment, the respondents has scattered idea. The table below brings to us that 30.66 % of the populations have no idea about it. Highest 60 % has told about the Upazilla

Table 1. Distribution of population by Schooling status, level of education and menstruation

Level of education				First menstruation	
Indicator	Percent	Class	Percent	Age (years)	Percent
Never attend school	8.0	0	8.0	7-9	6.0
Currently in school	40.0	1-4	46.0	10-12	70.0
Drop out	52.0	5-8	32.0	13-15	14.0
				15 +	0.0
Total	100	9-10+	14.0	Unknown	10.0

Table 2. Knowledge about healthy measures and sources should take during first menstruation*

Awareness about healthy measures during menstruation		Sources of information	
Measures Taken	Percent	Measures taken	Percent
Use old cloths	36.33	Friends	2.0
Sanitary/cotton pad	13.33	Mother	32.33
Soap/ savlone/Dettol	9.37	Grand mother	2
Clean dry cloths	15.66	Sister	30.33
Not eating fish-meat	0	Cousin sister	12.0
Not going out of house	5.66	Aunties	4.0
Not taking pin religious activity	10.0	Neighbors	11.33
Eat good & nutritious food	0	Health workers	4.0
Use hot water	6.66	Teachers	0
No measures should taking	0	Radio/TV	2.0
Use Pantry/ underwear	2.99	Doctors	0
Don't Know	0	Newspapers	0
Total	100.0		100.0

*Multiple Responses exist

Table 3. Distribution of study population by age of having first menstruations in life

Age	Percent	Problems	Percent
7-9 years	0.0	Lower abdomen pain	46.6
10-12 years	34.66	Hip joint pain	23.96
13-15 years	65.34	Irregular menstruation	3.6
15 + years	0.0	Excess blood loss	8.5
Don't Known	0.0	Less blood loss	6.64
Total	100	Loss of appetite, Vertigo, Headache	10.7

health complex is the place for treatment of reproductive health problem. 31.33 % identified private clinic/ qualified doctor, 20.66 % told for FWC, 8.66% for district hospital and4.66 % told for permanent clinic. On the other hand 6.66 % has told Air Fakir Hujur and 3.33 % for village/ traditional doctor and 3.33 % for pharmacy. Other 2 % claimed MCWC and 2.66% for HA/FWA.

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 2.8 describes the service provider's attitude. Behavior and practice towards clients. 61.11 % were welcomed, 66.66% said that they have showing interest on them and 55.66 % replied no one were in the same room where they received treatment. Besides, 88.89 % said the service providers were not examining the client, 94.45% claimed for not maintaining privacy during giving services and not taking consent for examination. 100 % of them were claim against not using separate room for examination, not explaining any things, not using pictorials for making understanding, not share follow up time and places and also do not refer any client. In Bangladesh, Marlow *et al*. (2016) cited that women were strongly influenced by health providers when deciding which method to use.

Satisfaction on health care service: Figure 3. 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.

Table 4. Response of the population by attitude and practices of service providers on reproductive health during first menstruation

Service providers	Percent	Types of facilities	Percent	Types of facilities	Percent
Qualified doctor (MBBS)	33.33	District Hospital	6.33	Private clinic	20.33
Nurse/FWV/FWA/HA	8.33	FWC	10.33	Pharmacy	2.33
Home / Ayurvedic	0	Upazila Health Complex	30.33	Village doctor	3.33
Village doctor	16.66	HA/FWA/MCWC	2.67	Pir/ Fakir/Hujur	3.33
Others (specify) Kobiraj	41.66	Permanent clinic	3.67	Don't Know	17.33

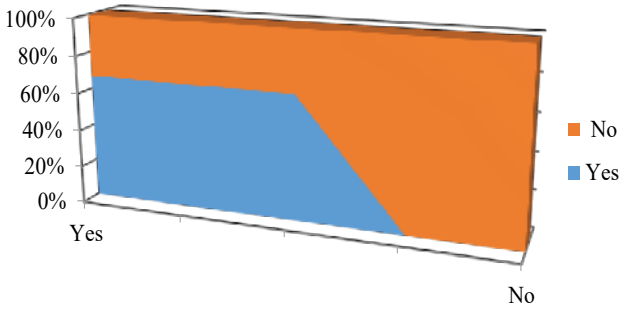


Figure 3. Distribution of population by level of Satisfaction on health care service received

Conclusion: The study indicates that the 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. A mechanism needs to be devised for improving adolescent's knowledge and imparting that knowledge in practice. Parents, guardians, teachers, religious leaders and immunity leaders (they are main gatekeeper) concerns regarding management reproductive health issues of adolescent females often acted as a great barriers to reaching them. It will be extremely difficult to work with adolescent females without their whole hearted participation and support. Strategies need to be taken for creating positive change in the behavior and attitude.

Besides appropriate information, the other most critical need is that of easily accessible reproductive health services for the adolescent. While married adolescents still have some access, but the unmarried ones with reproductive health problems have almost no option for accessing services. Utilizations of services both information and treatments, through adolescent friends centers would depend to a large extent upon the adolescent's and their guardians knowledge about the existence of such centers and also their opinions/ views about these centers. Strategies need to be taken to reach them both gatekeepers and adolescent females to make them understandable that this for their wellbeing and ensure their participation.

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