

Knowledge Brief

Health, Nutrition and Population Global Practice

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN DHAKA'S SLUMS, BANGLADESH

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October 2014



KEY MESSAGES:

- Adolescent fertility is a significant concern in Bangladesh, with 80.6 births per 1,000 women 15 through 19 years of age, more than twice the average in the Asia region.
- Results from this study indicate that roughly one-quarter of girls 15 through 19 years of age are already married; and by 19 years of age, 70 percent have had a child.
- The modern contraceptive prevalence rate among girls in the Dhaka slums is similar to the national average at 61 percent.
- Though three-quarters of pregnant adolescents in the slums receive at least one antenatal care (ANC) visit, only 25 percent receive the recommended number of visits.

Introduction

Adolescents around the world face tremendous challenges to meeting their sexual and reproductive health (SRH) needs. Inadequate access to health information and services, as well as inequitable gender norms, contribute to a lack of awareness about puberty, sexuality, and basic human rights that can have serious implications on their health and welfare throughout the rest of their lives. These underlying factors lead to high rates of early pregnancy, sexually transmitted infections (STIs), sexual violence, and early and forced marriage globally.

Research has found that adolescence is a profound and complex stage of life that influences future health outcomes, attitudes, and behaviors. Using a life course-perspective requires understanding the relationships between early childhood health and development and its effect on adolescence; the importance of biological changes, cultural traditions, and social norms associated with puberty; as well as the influence that social determinants have on adolescents' up-take of health-

related behaviors. To improve and promote adolescent health, development and well-being, it is also important to acknowledge the broader policies and environment in which they live, learn, work, and form relationships (Sawyer 2012).

The environmental impact on adolescent health and development is clearly seen in the slums of Dhaka, Bangladesh. The Dhaka slums are home to an increasing number of adolescents and youth who migrate from rural areas in search of work and a better life. They end up finding unhealthy and unsafe living conditions, and find themselves at great risk of sexual and gender-based violence and harassment. Although many girls and young women living in the slums are able to find paid work, they often lack access to basic health information and services, face gender inequality, and confront traditional and often harmful expectations regarding marriage and childbearing.

To date, there has been little understanding of the life of adolescents in the Dhaka slums. To address these issues, the World Bank, with the International Center for Research on Women (ICRW), conducted a study to

determine the key barriers to adolescent sexual and reproductive health (ASRH) in Dhaka, and understand how these barriers are influenced by programmatic and policy interventions. The Bank and ICRW used mixed methods research, interviewing hundreds of married and unmarried girls, young men, young women, and key stakeholders in four diverse slums of urban Dhaka. This knowledge brief provides a brief background on ASRH in Bangladesh and summarizes the results of this study.

The Context: Bangladesh

Bangladesh is a low-income country with a gross national income (GNI) per capita of US\$829 (World Bank, 2013). Young people (10-24 years of age) represent 31 percent of the total population with a significant proportion living in poverty. About a third of Dhaka's residents are poor and nearly half live in slums. More than half of adolescent girls (55 percent) and 48 percent of boys are enrolled in secondary school. The majority of garment workers are female (85 percent), of which 50 percent are adolescent girls. The country has one of the highest rates of child marriage: 29 percent are married by age 15, and 65 percent by age 18. The contribution of adolescent fertility to the total fertility rate in Bangladesh has increased from 20.3 percent in 1993, to 24.4 percent in 2007 and 25 percent in 2011 (DGFP, 2013). In Dhaka, almost 29 percent of girls 15-19 years of age have already started childbearing (NIPORT et al., 2013).

Research Methodology

The study included a three-part research project: (1) Quantitative household surveys involving 320 married adolescent girls; (2) Qualitative interviews, including a donor scan and interviews; in-depth interviews with 16 married and unmarried adolescent girls; focus group discussions with young women; and key informant interviews with health care providers, representatives from non-governmental or community-based organizations, traditional healers and staff from government centers / clinics; and (3) Formative Research with young men in the form of focus group discussions.

Findings of the ASRH Study

The study findings are consistent with existing data and evidence regarding adolescent sexual and reproductive health and rights (SRHR) in Bangladesh. The findings show that adolescents and youth in Dhaka slums face even more barriers in exercising their SRHR than their counterparts not living in slums. The following is a summary of the study findings.

ADOLESCENT MARRIAGE

Roughly one-quarter of girls 15 through 19 years of age living in the slums are already married. Of the 320 married girls (15-19 years old) surveyed, the vast majority were married between the ages of 12 and 17 years. The

youngest was married at 9 years old, and the average age of marriage was 15.2 years. Girls who had completed primary education were significantly less likely to be married before 13 years. Girls whose mothers had at least some education were also significantly less likely to marry at very early ages compared to those whose mothers had no education.

Married girls participating in the in-depth interviews were asked to describe how they met their husbands and how they married. Half reported that they met their husbands on the way to or from work. The other half stated that family members, often the older siblings, forced the girls into a marriage.

When asked at what age they would like to get married, unmarried girls participating in the qualitative interviews reported that their ideal age would be between 19 and 20 years; several stating that this was so they could have more time to earn money before getting married. One unmarried 15 year-old said, *"Marrying now would create too many physical problems for me. Besides, my family has financial problems. I want to settle those first and then get married."* Many of the married girls and young women in the qualitative interviews reported that their expectations of marriage were not met, as their husbands did not take enough care of them financially and spent most of the time outside of the home.

EARLY PREGNANCY AND CHILDBIRTH

Recent reports indicate that in Dhaka, almost 29 percent of girls 15 through 19 years of age have already started childbearing, with the vast majority taking place within marriage (NIPORT et al., 2013). The current study indicates that these rates are significantly higher in the slums where nearly 52 percent of girls aged 15-19 years have had at least one child (Figure 1). The majority (83 percent) of the girls who were married but did not yet have children said they wanted to have two children, and almost half wanted to wait at least two years before their first birth.

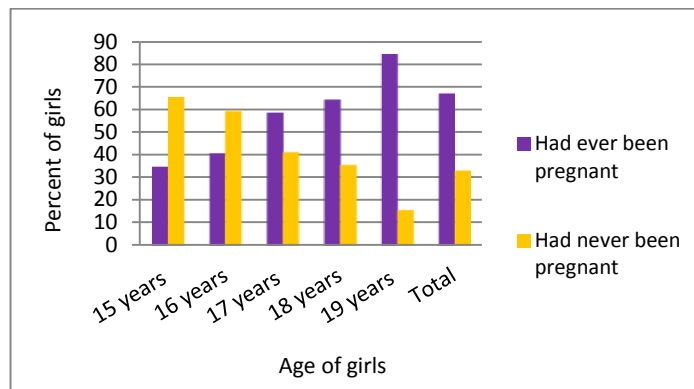
Although the majority of married girls interviewed had been pregnant by the age of 19, when asked their ideal age for first pregnancy 89 percent of them said that women should be at least 20 years of age before becoming pregnant for the first time.

CONTRACEPTIVE KNOWLEDGE AND USE

Nearly all (99 percent) married girls knew of at least one method of contraception, while 61 percent stated that they used modern contraception (equal to the national average). Nearly 7 percent used traditional methods, and 32 percent reported using no method at all. The specific methods that girls knew about coincided with the contraceptive methods they were using. Only 40 percent of the girls knew about male sterilization or IUDs, and just 10 percent had heard of emergency contraception. Of those who were not using contraception, the primary

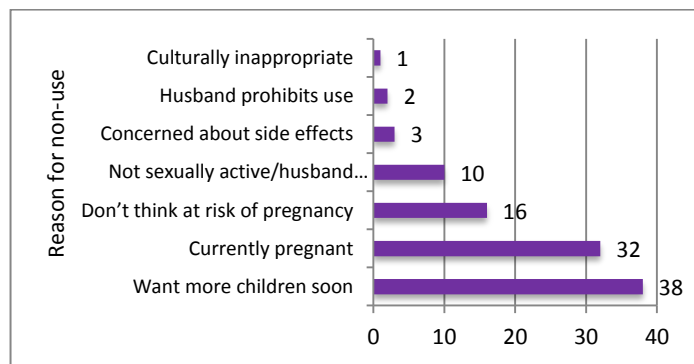
reasons were: a desire to become pregnant (37 percent), currently pregnant (31 percent), or prohibited from using contraception by their husband or cultural reasons (3 percent) (figure 2).

Figure 1. Percentage of 15-19 year olds who have ever been pregnant, by age (N=320).



Source: World Bank Group and the International Center for Research on Women. Household Survey 2014: Adolescent Sexual and Reproductive Health in Bangladesh. 2013.

Figure 2. Reasons married adolescents (15-19 years) do not use contraception (percent) (N= 102).



Source: World Bank Group and the International Center for Research on Women. Household Survey 2014: Adolescent Sexual and Reproductive Health in Bangladesh. 2014.

The qualitative interviews and focus groups found low levels of knowledge and use of contraception among unmarried girls. None reported using contraception. Given that premarital sex is highly stigmatized in Bangladesh, unmarried adolescents face extremely limited access to contraception (whether due to organizational policies, perceptions of such policies, or stigma), creating a significant impediment to their understanding of and ability to express their SRHR.

ANTENATAL CARE (ANC) AND CHILBIRTH

Young women in Bangladesh access health services, including ANC, at very low rates. Recent data indicate that even in urban areas, only 45 percent of pregnant women attend the recommended number of four ANC checkups. The current study found low use of ANC

services, with lower rates in the slums. While three-quarters of pregnant girls received at least one ANC visit, only 25 percent received the recommended number of checkups. Girls who received ANC received it from either a government or municipal hospital or center (38 percent), a center affiliated with a non-governmental organization or university (39 percent), or a health worker visiting their home (40 percent).

The majority (70 percent) of girls who had given birth delivered at home (their own home or that of a relative). These findings are similar to national level results. The reasons given for not delivering in a health facility were that it was not customary (66 percent), expense (24 percent), and lack of time (9.5 percent). Nearly 5 percent of girls who delivered at home did so because their husband or other family member did not allow them to visit a health facility at birth. Midwives or relatives assisted the majority of girls' deliveries, and most girls who gave birth (71 percent) said that they had not met with a health worker in the three months prior to the delivery.

GENDER-BASED VIOLENCE

The study found that sexual and gender-based violence was quite common in these communities (figure 3). While many respondents expressed disapproval of such violence, a high percentage believed that spousal abuse was acceptable in a number of circumstances. Over 13 percent believed a husband was justified in beating his wife if she refused to have sex with him, almost 29 percent believed it was acceptable for him to beat her if she went out without telling him, 35 percent believed it was acceptable if she did not take care of the house or children, and 55 percent said it was acceptable if the wife disrespected her in-laws. Similar beliefs were found in in-depth interviews and focus group discussions. Forced or coerced sex —both inside and outside of marriage — was reported as fairly commonplace in the qualitative interviews.

Challenges

As is the case with adolescents and youth in many parts of the world, adolescents living in the Dhaka slums lack access to basic information pertaining to their bodies and regarding their rights to reproductive autonomy and bodily integrity. Gender and cultural norms, stigma related to adolescent sexuality, myths and misperceptions, poor implementation of existing laws regarding age at marriage, and unclear policies and practices related to the provision of services for unmarried adolescents all contribute to low levels of knowledge and access to accurate and quality information and services, as well as to harmful practices and norms. Early marriage and pregnancy are the norm for girls, despite the legal age of marriage being 18 years.

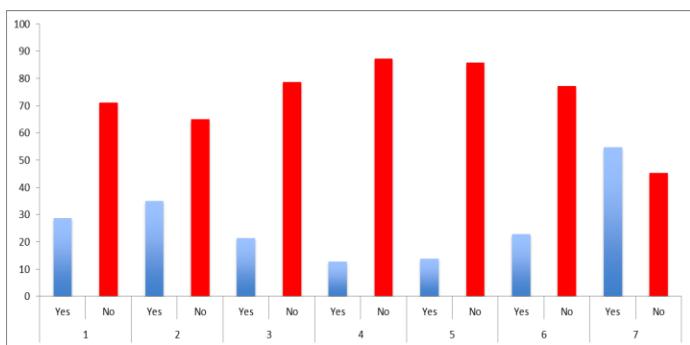
Recommendations

To address the above challenges, the following interventions are recommended.

First, basic fertility awareness education for boys and girls is needed. Misperceptions, myths and poor knowledge related to puberty, the menstrual cycle, and gender roles can be addressed through programs targeted at different age groups within the slum communities.

Second, there should be more opportunities for collaboration between the formal and informal sectors providing SRH information and services, as well as training on the benefits of facility-based births and the differences between normal reproductive bodily functions and symptoms that may be cause for concern.

Figure 3. Reason husband is justified for hitting his wife (among adolescents 15-19 years of age) (percent)



1. Goes out without telling husband; 2. Does not take care of children/house; 3. Gives different opinion than husband; 4. Refuses to have sex with husband; 5. Does not cook food; 6. Suspected of being unfaithful; and 7. Shows disrespect to in-laws

Source: World Bank Group and the International Center for Research on Women. Household Survey 2014: Adolescent Sexual and Reproductive Health in Bangladesh. 2014.

Third, the government should ensure that laws regarding sexual violence are enforced, and support is provided to local programs that sensitize community members to the dangers of gender-based violence, helping girls and community members to respond to violence.

Fourth, to address some of the harmful gender and social norms surrounding early marriage and girls' education, there should be more socialization campaigns involving men and boys that emphasize the benefits of joint decision-making and dispel inequitable gender norms.

Local organizations that develop and facilitate clubs and groups for adolescent girls and boys (separately) should be supported. Ideally, these groups would provide

information and counseling about SRH, including destigmatizing normal body functions and dispelling the superstitions and fears that keep girls from using SRH services in the formal sector (such as delivering in health facilities). Even groups that simply bring girls—married and unmarried—together can help to reduce the social isolation they face in these communities.

Fifth, in addition to programs for adolescents, outreach should target older family and community members, such as the mother-in-law, on the importance of ANC and the advantages of skilled birth attendance. Results indicate that older family members and community stakeholders are often the ones reinforcing limited ANC checkups and home delivery.

Conclusions

Through numerous forward-looking policies, the government of Bangladesh has indicated its intent to advance the agenda for ASRH. With the political will to follow through on these policies, and with the support of donor governments and other agencies, much can be done to provide adolescents and youth in the slums of Dhaka, Bangladesh, with access to the information and services they need to not only survive, but to thrive in more equitable, safer, and healthier communities.

References

Cortez, R., L. Hinson, and S. Petroni. 2014. Adolescent Sexual and Reproductive Health in Dhaka's Slums, Bangladesh. 2014. HNP Discussion Paper. The World Bank, Washington, DC (Forthcoming)

National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2013. *Bangladesh Demographic Health Survey 2011*, Bangladesh and Caverton, MD: NIPORT, Mitra & Associates and Measure DHS.

Sawyer, S.M., Afifi, R., Bearinger, L., Blakemore, S.J., Dick, B., Eze, A.C. and Patton, G.C. 2012. Adolescence: A Foundation for Future Health. *Lancet*, 379: 1630-40.

This HNP Knowledge Brief highlights the key findings from a Study "Adolescent Sexual and Reproductive Health in Dhaka Slums, Bangladesh" Health, Nutrition and Population (Forthcoming). Rafael Cortez (World Bank), Laura Hinson (International Center for Research on Women, ICRW), and Suzanne Petroni (International Center for Research on Women, ICRW). This report was part of a series of multi-country adolescent SRH analysis prepared under the Economic Sector Work (P130031) conducted by the Health, Nutrition and Population Global Practice and funded by the Bank-Netherlands Partnership Program.

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