TOWARDS ADOLESCENT FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES

REPORT OF QUALITY RESEARCH FOR REPRODUCTIVE HEALTH INITIATIVES FOR YOUTH IN ASIA (RHIYA) PARTNERS IN BANGLADESH

PERCEPTION OF ADOLESCENT AND YOUTH ON QUALITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

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List of Acronyms and Abbreviations

AIDS	Acquired Immune-deficiency Syndrome
ANC	Anti Natal Care
BDRCS	Bangladesh Red Crescent Society
CBSG	Capacity Building Service Group
CWFD	Concern Women for Family Development
FGD	Focus Group Discussion
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
HIV	Human Immune-deficiency Virus
IEC	Information Education and Communication
MSCS	Marie Stopes Clinic Society
NGO	Non-Governmental Organisation
PNC	Post Natal Care
RHI	Reproductive Health Initiatives
RHIYA	Reproductive Health Initiatives for Youth in Asia
SCF	Save the Children Fund
SDP	Service Delivery Point
SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
UNICEF	United Nation Children Fund
USAID	United States Assistance for International Development
WHO	World Health Organisation

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Finally, while acknowledging the valuable inputs of all the above, the review team stands by the data, analysis and conclusions reached from the monitoring survey and believes them to be a sound response to the information available. However, the review team also recognizes that the findings, analysis, and conclusion including any errors and omissions contained within this report are its own.

- Study Team

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Section-I: Introduction

1 BACKGROUND

Adolescence- a time of transition from childhood to adulthood, when young people experience changes following puberty but can not immediately assume the roles, privilege and responsibilities of adulthood. Experiences of adolescence vary by age, sex, marital status, class, religion and cultural context. Moreover, social, economic and political forces are rapidly changing the ways that young people must prepare for adult life. These changes have enormous implications on adolescents for their education, employment, marriage and child bearing, but also for their sexual and reproductive health and behaviour. As a group, thus, adolescents have sexual and reproductive health needs that significantly differ from the adults in important ways, and which remain poorly understood and/or served in many parts of the world. Neglect of this population has major implications for the future, as sexual and reproductive behaviours during adolescence have far reaching consequences for people's lives as they develop in to the adulthood.

Analysis of available data suggests that adolescents in Bangladesh are exposed to the similar reproductive health risks as adolescents in other developing countries. Compared with other age groups, adolescents in Bangladesh tend to have fewer contacts with the health care system, regardless of their need for specific services. Bangladesh reproductive health statistics (BBS, 1998) show that 12.7 percent of adolescents were already married. Although the use of contraception is on the raise among married adolescent, the unmet needs still remain high. Almost 40 percent of 15-19 years old married girls do not use contraceptives. 35 percent of pregnant women are still at their teen. The higher death rate among girls compared to boys in 15-19 age group (1.81 as against 1.55 per 1,000 population) is mainly due to maternal causes. According to a USAIDS study, Bangladeshi adolescents have the least knowledge about the transmission of HIV/AIDS compared with the adolescents of some other developing countries. Risk factors like the high prevalence of STIs, increasing number of intravenous (IV) drug users, widespread poverty, low status of woman, commercial sex industry, and the present HIV/AIDS situation in India and Thailand predisposes Bangladesh for an HIV/AIDS crisis. So there is an urgent need for HIV/AIDS awareness program among adolescents of the country.

The development and provision of youth friendly reproductive health services is a long-term issue for Bangladesh, especially for unmarried adolescents and youth. Public as well as private sector does not offer clinical services that are tailored to the young adults. The RHIYA project endeavours to promote specialized providers, convenient hours, age appropriate IEC materials, additional time for counselling, special educational sessions and reduced fees for the adolescents and youths. Clinical services will include the entire range of SRH-FP counselling, dispensing and management of complications and side-effects, management of STIs, ANC/PNC and post-abortion Care for married adolescents and youth, TT immunization, reproductive and general health consultations, limited pathological tests and condom counselling and distribution. Service charges will be maintained at an affordable range. More over, qualitative aspects such as acceptability of the fee structure, accessibility of location and opening hours, acceptability of the waiting time and over all client satisfaction are important aspects for the RHIYA project. A referral network suitable to GOB or NGO facilities will be set up to help those clients whom MSCS will not be able to provide required services. MSCS has provision of quality services through its

four RHI clinics from the phase I of RHI project. In order to ensure client satisfaction and excellent technical standards of all services, existing quality of care protocol will be replicated. The protocol will regulate and monitor quality care in areas such as counselling, provider's behaviour, client registration and discharge, clinic environment and technical procedures against set standards and will be reviewed annually.

RHIYA in Bangladesh is implementing six projects in partnership with NGOs, including an umbrella project support unit based at UNFPA. The NGOs are operating 23 urban centres in various parts of Bangladesh. This programme mostly focusing on the urban poor, vulnerable adolescents and youths' reproductive and sexual health needs and information. Marie Stopes Clinic Society (MSCS) is one of the partners of RHIYA and is implementing 'Better health for urban young people'. MSCS is mandated to establish young people friendly space, provide clinical services for the young people, conduct advocacy programs for them and work through peer approach. MSCS is the lead partner for 'quality' issues and develop a standardized culturally appropriate clinical service delivery package for RHIYA Bangladesh. It has already formed a core group from the RHIYA partners and will engage a consultant to work with this group for developing their capacity as well as development of a technical and non-technical standard manual, review QAT guidelines with information from a QOC research. The quality research has been carried out to obtain the client's perspective on what 'quality services' mean to them. The clients, both male and female are between the age group of 10 to 24 years.

1.1 Objective of the study

The overall aim of this research:

To develop a model/outline of Quality Adolescent Sexual and Reproductive Health Services through understanding the client's perception, which will contribute RHIYA project to develop an adolescent friendly quality sexual and reproductive health service protocols.

1.2 Specific Objectives

To understand the explanatory models (including vocabularies) of Quality SRH Services (including the elements/components of Quality) perceived by the Young People to examine the existing system/definition of Quality services.

From the Adolescents' perspective, to find out:

- How do young people/adolescent perceive quality; what are the attributes of "Quality" Health Care Services for the young people/adolescents.
- Suitable time and location for the adolescent to obtain sexual and reproductive health services (accessibility)- adolescent are able to obtain them;
- Package of essential sexual and reproductive health service they require to meet their demand- services that are required for adolescent (appropriateness);
- The extent of services they want- services that are offered to them meet all their demand (comprehensiveness);
- Type of behaviour they expect from the service provider while availing health services- style of delivering services are acceptable to them.

- Privacy and environment they want during presenting their case to service providers and availing services, and
- Type of skills and technical competencies required to provide services and how much time adolescent would like to avail services-waiting time and appoint systems etc.

1.3 Scope of work

- Interview adolescent (300 male and 300 female) through developing a questionnaire and conduct fifteen FGDs with adolescents and service providers.
- Observe/review registration procedures, waiting time, appointment systems, service providers' behaviour, environment (including privacy) of service delivery five outlets (one from each NGOs).
- Observe health education services.
- Develop and finalise questionnaire in collaboration with MSCS

Section – II: Methodology

2 METHODOLOGY AND IMPLEMENTATION

This is an explorative study. This research adopted a combination of social and statistical research methodology to optimise the data validity and presentation. Thus it has drawn upon the qualitative and quantitative research approach. Specifically, the research team was dependent on survey, FGDs and document review for the research inquiry.

2.1 Survey:

Survey was used to capture the response of key research questions from the audience with variety of socio-economic characteristic. The survey itself attempted to capture information that was sought in the study quarries. A structured and mostly pre-coded questionnaire was administered among 600 adolescents in the project area. It has captured both quantitative and qualitative information from the members through interactive personal interviews.

2.2 Focus Group Discussion (FGD:

In this research, FGDs were conducted after the data ranges, frequency distribution and descriptive tables were available from survey data. This had provided helped to design the FGD framework and to identify the information requirements. This process also helped validate survey findings of quantitative nature. Therefore, FGD effectively complemented and supplemented the quality research with perspectives and view points of various groups within the catchments population. A total of 15 FGDs, 3 from each of 5 SDPs (targeted to one male, one female and one service providers) were conducted.

2.3 Study Area:

The study covered a representation of catchments area of the overall RHIYA project. In that, the catchments area of all five-consortium partners of RHIYA were brought under consideration. A total of 5 SDP areas, one each from RHIYA partner NGOs, were taken for survey. These areas were:

- MSCS catchments area at Mymensingh
- FPAB catchments area at Netrokona
- SCF-UK partner Solidarity catchments area at Kurigram
- BDRCS catchments area at Banglabazar, Dhaka
- CWFD catchments area at Gazipur

2.4 Sample size

Overall sample size was 600 respondents - 300 male and 300 female. Among each 300, 150 were clinic visited adolescents and rest 150 were RHIYA beneficiaries but never visited clinic.

A simple and straight forward sampling procedure was used to determine a representative sample size that would allow scientific statistical tests to be performed to draw conclusions.

The baseline survey list available at the SDP site constituted the overall sampling frame. Sampling frame for clinic-visited beneficiary was the client list of SDP clinics,

and for never visited beneficiary, baseline survey list excluding the visited beneficiaries.

Overall, 600 samples were equally drawn from beneficiaries who have visited the RHIYA clinic at least once (300) and never visited (300) but listed under baseline survey as potential beneficiary. This process considered that samples were equally distributed between male and female. Maintaining this distribution process, 120 samples have been drawn from each of the 5 NGOs. A detail plan is depicted in the following matrix.

<table>
<tr><td colspan="4">Sample sixe (n) = 600</td></tr>
<tr><td colspan="2">300 visited RHIYA clinics at least once</td><td colspan="2">300 never visited RHIYA clinics</td></tr>
<tr><td>150 male</td><td>150 female</td><td>150 male</td><td>150 female</td></tr>
<tr><td>30 per NGO (30X5 NGOs)=150</td><td>30 per NGO (30X5 NGOs)=150</td><td>30 per NGO (30X5 NGOs)=150</td><td>30 per NGO (30X5 NGOs)=150</td></tr>
<tr><td colspan="2">Beneficiaries visited clinic 60 per NGO</td><td colspan="2">Beneficiaries never visited clinic 60 per NGO</td></tr>
<tr><td colspan="4">120 samples per NGO x 5 NGOs = 600 Samples</td></tr>
</table>

2.5 Sampling procedure:

As we know the catchments population of the program, CBSG used following formula for determining the sample size. This formula is applicable for population size ranging from 50,000 to 1,000,000 and widely used in development and social studies.

$$n = \frac{z_{1-\alpha/2}{}^2 pq * N}{d^2(N-1) + z_{1-\alpha/2}{}^2 pq}$$

where, N= population size

p = .50 (it is assumed that project has reached to 50% targeted beneficiaries)

q = 1-p

d = precision level of the proportion

z = 1.96, for 5% level of significance

In this case, number of beneficiaries are said to be 250000 (RHIYA is expected to reach 250000 beneficiaries directly, ref. Project document of RHIYA, page 9)

So,

N = 250,000

p = .50

q =.50

d =.05

Equating this formula, we got a figure of 383 samples that represent the catchments population. Then adding design effect by multiplying 383 into 1.5 provides a figure of 574 (as the samples will be drawn from 5 different locations). This was the minimum number of sample to be drawn. However, for better representation and considering time and cost, a size of 600 samples were studied in this research.

2.6 Identification of Primary Sampling Unit (PSU)

120 samples were drawn from each of the 5 areas equally distributed between male and female adolescents. That was 60 male and 60 female. Ultimate sampling units were selected using exiting client list. Systematic random sampling method using K^{th} number were used to specify the adolescent. However, in case of non-availability or missing respondent, next number from the existing client list was chosen for interview

2.7 Research tool development:

Survey Questionnaire:

Survey questionnaire was developed through a rigorous and consultative process between CBSG and MSCS. The following steps were followed during questionnaire development:

- Identified key issues and indicators coherent to study objectives from document review
- Prepared a list of dimensions of quality SRH services for adolescents in consultation with MSCS counter parts.
- Conducted semi structured and open ended interview with clients of different age group and sex
- Prepared a draft questionnaire with code options
- Share with MSCS and get their input and finalize a draft for pre-test

The survey questionnaire is attached as annex-!!!

FGD Guide Questionnaire:

Capitalising on the experience of data collection and analysing descriptive table, a thorough FGD guide questions were developed. This questionnaire is attached as annex -!!!

2.8 Review of training modules, materials and documents:

CBSG also reviewed the project documents including service manual, training materials, reports and other relevant documents coherent to this research.

2.9 Implementation

The quality research begun with the inception and briefing meeting with the management of MSCS. Then relevant documents, concept papers were reviewed. Afterward a detail implementation plan including timeframe and responsibilities was chalked out.

The next task was the development of survey instruments, guides, FGD guidelines. All these tools were refined through filed test in multiple locations and context. Before the survey work, all the field enumerators were provided with classroom and field training. Fieldwork was undertaken with intensive supervision and required

quality control mechanism installed at various levels. Consultants made number of field visits during the fieldwork.

On completion of the fieldwork, the data was coded and analyzed using computerized data management system. Then the draft report was prepared and submitted to MSCS for their suggestions. Following section gives more detail of implementation.

2.10 Field Survey

A group of 12 enumerators familiar with NGO's health programme and experienced in field data collection – mostly female were deployed for the assignment to under take the field investigation. The data collection took place between 20th August and 5th of September, 2002. Field enumerators were divided into 2 teams and each team was guided guide by a Supervisor. The whole field investigation team worked under the guidance of a Field coordinator. The survey specialist coordinated the whole survey process.

2.11 FGD

FGDs were conducted once the preliminary analysis of field survey data was completed. FGDs were conducted between 7th and 12th September, 2004 by the key research team members.

2.12 Quality Control and Field Editing

As part of the quality control measures, around 10% respondent were re-interviewed by the respective field supervisors and required corrections were made on the spot. Field supervisors checked the completed survey questionnaire for any inconsistencies before departing from the field. The field supervisors, in turn, deposited the questionnaires to the field coordinator. The field coordinator and Survey Specialist checked the questionnaires for the second time. A further review was made at the team meeting that took place every day at the end of data collection to check the doubtful figures and to discuss field interviews with the participation of enumerators, field supervisors and the field coordinator for final check at the field level.

2.13 Final Editing, coding and de-coding

For open-ended and pre-coded queries, data editing, coding and decoding were done at central level in Dhaka. A team comprising field supervisor – experienced in editing, coding and decoding carried out whole task.

2.14 Data Analysis and management

Survey data was initially transferred into the electronic format using Access database which was then transferred into SPSS format that provided the main frame for data analysis. A Smart and conditional data-entry software was developed using a combination of Access and Visual basic to filter quality and consistency during data entry. Coding and de-coding were done to handle the data in the electronic form. A thorough consistency check was done before taking simple tables, data ranges, frequency distributions and descriptive tables. This basic tables worked as guide to develop a more detail and cross analytical tables for analysis.

2.15 Limitation of the study

The research team received required cooperation from all the counterparts came across during the course of research. However, there were some difficulties as well. The data collection team faced problem like getting adequate number of male visited

clients in some areas. In those cases, opportunistic sampling instead systematic random sampling were used to identity the respondent. Apart from this, the overall sample size was bare minimum in the context RHIYA catchments coverage. However, it was statistically proven representative.

Section – III: Findings

3 BACKGROUND CHARACTERISTICS

RHIYA project is designed to serve the underprivileged segment of the society through the NGOs. The research made an attempt to understand the actual characteristic and background of the clients. Client characteristics are particularly important in the context of perception survey as it can vary significantly between different groups of population.

Table 2 shows the background characteristics of the youth included in the survey. The dominant age group of the youth in the survey falls between 15 to 18 years - almost 50% of the survey respondents. More than a quarter is representing 19 to 24 years and less than a quarter is between 10 to 14 years.

Table 1. Background characteristics of the survey respondents

	Percentage		
Characteristics	Female (n= 300)	Male (n = 300)	Total (n=600)
Age (in years)			
10 – 14	31	13	22
15 – 18	47	53	50
19 – 24	22	34	28
Education			
No education*	1	4	3
Can sign only	2	4	3
Primary	30	24	27
Secondary	46	37	42
Secondary +	21	31	25
School enrolment	57	47	52
Marital status			
Married	25	7	16
Unmarried	75	93	84
Mean age of marriage	18	26	
Do work for money	16	45	30

* No education means never attended school

Education profile of the female indicates a better scenario than males. Majority (97 percent) of the female received education varying from primary to higher secondary level, in case of male it is 5 percent lower. School enrolment of female is 10 percent higher than male. The better situation of female could be the result of GOB program of scholarship and free education for females.

Regarding marital status, few (7 percent) of the males are found to be married during the survey. Compare to males a large portion, one quarter of females are married. The mean age at marriage for female is 18 years and male is 26 years. Among the married youth the age difference between spouse is found to be 7.6 years.

A reasonable proportion of the youth under study work for money. Almost half of the males and one fifth of the females are involved in earning process. The work pattern of female is different from male. Most of the female work at home mending mat, fan, sewing and embroidery on cloths. A few of them works in the garment factory. On the other, most of male are involved in service at different workshop, restaurant, etc.

Ninety one percent of the female's income or wage is less than Tk. 2000 monthly. Similar income are earned by 58 percent males. In general the male income are higher than females as 42 percent of them earn between Tk. 2001 to 3000.

The study youth come from lower middle class family. Their family income is on average Taka 6000 per month. Nearly one quarter of their father are employed in workshops, grocery shops, rickshaw or van puller, farmers, etc. About one third of them are in business such as selling vegetables or grocery things, etc. Almost seventy percent of the families have a television set.

Education levels of the father of the youth under study indicate that one third of them have no education or only can sign. One fifth of them obtained primary education, more than one third have secondary education and rest 10 percent have higher secondary education.

The study found that healthy living practice exists in the community. Almost three quarter of the female and male live with their parents during the study. Ninety percent of the married females live with their husbands.

4 COMPETENCIES OF YOUTH FRIENDLY SERVICES

4.1 Conceptualization of YOUTH Friendly Services

The need for youth reproductive and sexual health service and information is now globally recognized. Young people are especially vulnerable to health risks, specifically related to sex and reproduction. As, this stage of youth is associated with increased likelihood of sexual activities, which make them at risk of contracting sexually transmitted diseases (STD), including human immune deficiency virus/acquired immuno-deficiency syndrome (HIV/AIDS). Young people today are exposed to media, internet, Porno CDs making them aggressive for experimenting sexual activities.

The existing Reproductive health facility of public sector and most of the NGOs are primarily focused on married women and children and is not designed to address youth and adolescent health issues. A qualitative study, conducted by Ahmed S. in Dhaka's urban slums, supported this assumption and identified reasons among adolescent females for not using health facilities. The study found that adolescent female felt uncomfortable discussing reproductive health problems until and unless they had been recognized as serious. They reportedly felt that most health centers were run for adults, but not for them, particularly the ones who were unmarried Quamrun Nahar, Selina Amin, Rafiqus Sultan, Hazera Nazrul, Meghla Islam, Thomas T Kane, Barket-e-khuda, Cristobal Tunon: Strategies to Meet the Health Needs of Adolescents: A review, Special Publication, 1999. Review of different study also found male youth are not welcomed at the clinics and they are also shaky to visit these facilities.

Researcher, Policy Planners, Program Managers are concentrating more in this emerging new area. Agencies, especially nongovernmental organizations (NGOs), are looking at new ways to serve this population more effectively and in ways that meet their particular demand. To increase young people's utilization of reproductive health services, these services need to be *Youth Friendly*. Characteristics of youth friendly services has been defined as follows-

Services are understood to be youth friendly if they 'have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate settings for youth, meet the needs of young people and are able to retain their youth clientele for follow-up and repeat visits.' Youth friendly services effectively attract young and provide quality reproductive health services in an environment that is comfortable and responsive 2[Kristin Nelson, Laurel MacLaren, Robert Magnani, Assessing and Planning for Youth – Friendly Reproductive Health Services, Focus on Young Adults, January 2000].

Views and perception of young population regarding youth friendly services has been searched for revision/modification of the existing facilities. Providers, clinical staff and other support staff at the facilities have also expressed their opinion for youth friendly services. The responses are presented as follows:

4.2 Accessibility

4.2.1 Convenient Location

Convenience of location of the Service Delivery Point (SDP) is important factor to youth. Location of the SDP is known to almost all the respondent. The SDP is within 1 to 2 kilometer radius from the respondents' home. They require 10 to 30 minute time to reach the SDPs. Majority (75 percent) of the females and males responded that they can easily reach the SDP while rest 25 percent differ to the opinion. 71 percent females and 59 percent males opined that the distance of the SDP should be less than one kilometer.

Although location of the SDP is found to be within the reach of majority of the respondents, but during Focus Group Discussion (FGD) with providers, male and female youth in Mymensingh has different views. Many youth stated that they had difficulty travelling very far away. Most of them said that it was too far from their home. Travel time and conveyance are not favourable to them. One of the male participants at the FGD said,

My father does not give me money for transport to visit SDP, it is difficult for me to visit. It will be better if SDP is within our locality.

Another female participant said, *after school we have to return home. To visit SDP and receive service from doctor I have to travel far away from my home. It become night to reach home and also the conveyance cost Tk.30, it is not affordable for us.*

The problems of location and affordability need to be taken into consideration.

4.2.2 Barrier to visit SDP

Questions were asked about the barrier they used to face to visit the SDPs. The major barrier identified by the youth were social taboos, criticism, shyness, economic insolvency, parents' restriction. Responses are presented in table 2.

Table 2: Barriers to visit SDP by youth

Barriers	Number and Percentage		
	Female (n= 268)	Male (n = 152)	Total
Community resistance, social taboos, criticism	98 (36.5)	82 (34.6)	
Parent oppose	35(13.0)	-	
Shyness	45(16.8)	55(23.2)	
Economic solvency	39(14.5)	60(25.3)	
Harassment, teasing	28(10.6)	22(9.3)	

More than one third of the females and males identified community resistance, criticism and social taboos as the main barrier for them to visit SDP.

Thirteen percent of the females experienced parents opposition to come to the SDPs. Youth males and females feel shy to visit there - 23 percent males and 17 percent female responded shyness as their main barrier. One fourth of the females and males mentioned harassment and teasing on the way to visit the SDPs. Similar findings came from FGDs with youth participants both male and female regarding harassment and teasing. One responded voiced –

Mohalla boys say bad things on the way to visit SDP.

Some female participants expressed their fear to take service from the providers.

Economic insolvency is identified as barrier for 14.5 percent females and 25 percent of males. Although distance is within reach of majority youth but few (8 percent) of them think distance as barrier.

Result from FGD with providers also mentioned community resistance and criticism as major barrier for youth to avail services from SDPs. Provider also mentioned record keeping system as barrier to provide services. They stated, 'it takes reasonable amount of time to record information of client. After recording we find very little time for counselling'.

Respondents were asked how to overcome/eliminate these barriers. Summarizations of their responses are presented in table 3.

Table 3: Opinion to overcome the barrier to visit the SDPs

	Percentage		
Opinion	Female	Male	Total
Community advocacy	56.5	90.8	72.0
Mass awareness	56.5	34.0	46.3
Field visit by doctors	2.7	4	3.3

From discussion with young population and service providers it is evident that community leaders, local elites, public representatives, school teachers, Imams, parents and gardens play a major role for creating enabling environment for utilization of health services. Community Advocacy could be a reasonable solution to overcome the barrier as suggested by majority of the respondents. Similar opinion was found in the FGDs with providers and youths. They stressed the need to strengthen community participation by involving Community representatives.

It was strongly suggested by the male and female youth for advocating parents. Meetings and orientation of parents by community organizers and counsellors suggested.

Mass awareness through media (TV, Radio, etc.) was suggested. A few of the respondents opined filed visit by doctor.

4.2.3 Convenient Clinic Hours

The issue of when clinics are accessible to youths interrelates two factors of clinic hours: when they are open and whether there are special hours for serving youths. Regarding convenient hours for SDP, majority of youth in study preferred SDPs to be open from afternoon to evening. Some of the male (13 percent) argued that they cannot attend SDP in week days as they do work, they want SDP to remain open in holidays. Similar response are given by 7 percent female. During FGD, male youth suggested for special days for Youth services. Table 4 reflected their opinion.

Table 4: Convenient clinic hours

Convenient hours	Percentage		
	Female	Male	Total
Early morning to before lunch	37	21	29
Afternoon to evening	58	69	63.8
Friday & holidays	7	13	9.9

4.2.4 Accompany

Who will be the best accompany for the youth to visit SDP was inquired. Nearly half of the unmarried females preferred their mother and married females preferred their husbands to be the best company. On the other hand, the males preferred their friends to be the best companion. The criteria for choosing them are frankness, cordial, supportive and like-minded.

4.2.5 Affordability

Cost for services for the youth should be affordable, if cost are too high they constitute a barrier to avail SDP services. Results of the study indicate that, more than three quarter of the youth think less than Tk. 10 will be affordable for them. While 17.4 percent of both female and male suggested Tk. 11 to 20 will be reasonable. It is to be mentioned here that a reasonable amount (female 14.5 and male 25.3 percent) were not able to pay, they identified economic inability as their barrier for accessing services.

It is worth mentioning here that researchers learned from young people in a cross-cultural study (Kenya and Nicaragua), most adolescents could not afford very much, but would rather pay something because they tend to view free services as being of poor quality.

Policy Implication:

- ***Community involvement is a leading factor to programmatic success and sustainability, area specific initiatives are required.***
- ***Appropriate Advocacy efforts require to bring change at the local, regional, or national level by targeting stakeholders who influence the acceptability of providing reproductive health information and services to young people***
- ***TV and Radio can be used for addressing mass population***
- ***Location of the clinic/SDP should be within the reach of young population, convenient hours and affordable fees should be fixed instead of free services.***

4.3 Information and Service need

Youth/Adolescents need age-appropriate information about physical and emotional development, the potential risks of unprotected sex, substance abuse, how to access health services, and educational, vocational, and recreational opportunities (WHO/UNFPA/UNICEF 1999). The need for information and services are identified from youth perspective both from survey and FGDs.

4.3.1 Information Needs

The youth expressed their needs on number of topics. Their responses are given in table 5 (Multiple responses included).

Table 5: Youth need for information on reproductive health issues

	Percentage		
Issues	Female	Male	Total
Menstruation	74.0	4.3	39.2
Wet dreams	8.3	71.7	40.0
Family Planning	29.3	12.0	20.7
Sexuality	17.0	37.0	27.0
Marriage	14.3	6.7	10.5
Substance use	14.3	32.0	23.2
Irregular Menstruation	38.0	1.0	19.5
Delivery	17.7	2.0	9.8
HIV/AIDS	26.3	50.3	38.3
Sexual diseases	19.3	63.7	41.5
Reproductive Rights	6.3	4.0	5.2
Leucorrhoea	20.3	-	10.3

From table 5 it is revealed that 75 percent of the females wanted to know about menstruation while 72 percent of the males wanted to know about wet dreams. The next important issue reported by the female (38 percent) was irregular menstruation and by the male (64 percent) is sexual diseases. The third issue mentioned by female (29.3 percent) was family planning and males (50.3 percent) HIV/AIDS. The next preference subject by female (26.3%) was HIV/AIDS and males (37.0%) sexuality. Compare to female more males (32%) wanted to know about substance abuse where only 14 percent female mentioned it. A very few of the female and males wanted to know about marriage and reproductive rights. A general review of responses from males and females reflected gender preference on the subject/topics of interests.

Twelve topics have been identified by youth, although some of the topics can be merged to one group, such as menstruation and irregular menstruation. During FGD with male they wanted to know the reasons of wet dream and its prevention, bad effect of masturbation and solution to it, use of condom, relationship with opposite sex.

4.3.2 Information Source

Issues relating to information transformation, such as how the youth want to get information, choice of person from whom they want to learn were asked. Media like television could be the best media to disseminate information and messages on reproductive health as it is suggested by majority (43%) of the respondents. They also mentioned other media such as books, magazine, poster, live drama show. During FGDs with peer leaders, providers and from in-depth interviews a common suggestion came out i.e. provide 'health education' at the SDPs. They opined that when we were waiting for services at the waiting space health education session would be helpful for us.

Regarding person choice majority of the youth mentioned fieldworker/community organizer name. They also preferred to learn from Counsellor and Peer leaders. But everybody have a bias for the doctor. Friendly attitude, good interpersonal communication skills, attentive, patience hearing were attributes of the person mentioned by the respondents.

4.3.3 IEC materials:

Effective IEC materials are needed for behaviour change of the youth. Youth was asked to give suggestion for IEC materials that could be attractive for them. Majority of the males and females commented Books as their first priority for information and education. Second preference was given for posters. Table 6 represents their opinion.

Table 6: Preferred IEC materials by youth

IEC materials	Female	Male	Total
Books	189	172	361
Posters	118	112	230

4.3.4 Service Needs:

Majority of the youth irrespective of marital status and sex has mentioned the need for reproductive health services including sexually transmitted diseases and prevention of HIV/AIDS. Female respondents have also mentioned services to cure irregular menstruation, abdominal pain during menstruation, leucorrhoea. Male mentioned of psycho-sexual problems and problems regarding size and shape of the male organ.

The married and unmarried service needs are reflected in table 7.

Table 7: Service needs of married and unmarried youth

Services

1. Sexually transmitted diseases
2. Prevention of HIV/AIDS
3. Treatment for irregular menstruation, lower abdominal pain during menstruation and leucorrhoea
4. Psycho-sexual counselling
5. Treatment and counselling fro Drug addiction
6. Skin disease

Policy Implication

- ***Topics of reproductive health issues has been identified by the youth, simple understandable message should be developed to address the youth***
- ***Common health problems experienced by female were irregular menstruation, abdominal pain and leucorrhoea and male's health problems were psycho-sexual, Strengthening of counselling service could improve this situation***
- ***Initiatives to develop National Policy for using mass media including TV for disseminating appropriate SRH messages for youth***
- ***Colourful, attractive books and posters containing SRH messages should be developed to attract majority of youth***
- ***Health education session could be arranged during waiting time***

4.4 Providers' Competency

Several questions were asked to the respondents to view their perception and demand from the providers. The result from in-depth interviews and FGDs shows that, in general, both males and females expects provider to possess human quality - Patience hearing, attentive, respect, good interpersonal skills, give enough time for discussion, skilled.

During FGD with youth, some negative impression was expressed by male youth. One responded-

'we do not want to see any discrimination among the clients. All clients should be treated equally. No one should look down by the provider.'

Another stated that, we are hurt by the way provider ask to keep the shoes off. They can say it in friendly manner'. Providers' attitude and behavior is an important factor in defining youth friendly services.

Regarding most preferred providers, 74% of the females and 67% of the male first choice is *'Doctor'*. Their next preference is for 'Counselor'. 29% females and 31% male voted for him/her. Skilled and experience is the first criteria suggested by both male and female. The score for next criteria varied among male and female. Table 8 shows point given for criteria to the providers.

Table 8: Criteria for choosing the providers

Criteria	Score		
	Female	Male	Total
1. Skilled and experienced	161	137	298
2. Lively, frank, easily approachable	85	128	213
3. Friendly, understandable, good interpersonal skills	108	35	143

Hundred percent of female and male agreed on the following:

- √ Take consent for any physical examination
- √ Explain the result of the examination
- √ Maintenance Privacy and confidentiality
- √ On an average 15 minutes times for consultation was suggested

Providers perspective on their competency has also been identified. During FGD with providers most of them said they need special training to serve youth. Some providers said they do not know how to deal with a drug abused. They need to know about it. The providers expressed their willingness to learn on youth reproductive health services and how to deal with it.

Appropriately trained providers who can address adolescents' specific biological, psychological, and health needs will help youth to take right decision as well as increase utilization of services.

4.4.1 Record Keeping and reporting

Record keeping and reporting helps program managers and providers to monitor the program. It is a key management tool for the program. It helps to identify problems. In all situations record keeping should be easy and friendly. In all FGDs, providers clearly expressed their dissatisfaction with the existing record keeping system. Provider thinks the present system is time consuming and complicated. One of the provider commented that- *present system is not a complete one*. They also mentioned that, presently they keep records of the youth and adolescents together with general clients. They do not write complete address of the youth clients in the recording format. It becomes difficult for them to identify and find list of youth services. In one of the FGD the provider stated that they do not write specific problems or name of the diseases in the register. To maintain confidentiality they do not write disease name instead write general illness or weakness. When further asked how they will report on disease profile of youth they could not give any solution. It revealed from discussion that record keeping system need revision and adjustment for efficiency of youth friendly services.

4.4.2 Referral Mechanism

From in-depth interview and FGDs with youth and providers it was found that referral system exists in each SDP. But impressions of youth indicate that it is not effective. One responded said, 'I went to a clinic but no one paid attention to the referral slips. They did not treated me well.' Most of the male and female expresses dissatisfaction on the existing system. They stated that there is no follow-up system for continuing services. On the other hand provider said they are overloaded and they do not have a system for follow-up. Only when by chance they meet the client inquire of his/her condition.

There is room for improving the system and program managers may look in to different referral sources and have clear operating plans for these.

Policy Implications:

- ***Provider should respect young people and show positive attitude – clearly defined code of conduct for the provider might enhance behavioural compliance***
- ***Providers need special training on counselling, management of drug abuse and psycho-sexual counselling***
- ***Record keeping system need revision and modification***
- ***Appropriate referral linkage need to be developed***

4.5 Environment Friendliness

Youth are generally less informed, less experienced, and less confident about sexual matters and reproductive health issues. Environment friendliness approaches are needed to attract, serve, and retain adolescents as reproductive health clients (Senderowitz 2003; Senderowitz 1999; Finger 1997). Emphasis has been given to create environment friendliness. Youths and providers has given their views and suggestions for youth friendly services.

4.5.1 Reception

Youth both male and female strongly suggested during FGDs that, there should be a reception space for youth and the Receptionist must be trained. He/she must cordially welcome youth. They also commented that First contact person holds important role and he/she must have knowledge on youth population. He/she should guide youth to take the services conveniently. They also mentioned for displaying direction of the provider and different service room.

4.5.2 Waiting space

Hundred percent of the male and female commented for separate waiting space for male and female. They want that the waiting space be more spacious. From FGDs it was found that, reasonable amount of youth felt uncomfortable in a crowded waiting space where adult and youth sits together. Youth recommended for separate waiting space for them.

4.5.3 Comfortable surroundings

Comfortable surroundings suggest a setting where youth are welcomed. It needs to be pleasing and comfortable and even relaxing and enjoyable. Youth have given their opinion in in-depth interviews and FGDs for creating comfortable surroundings. Result are given as follows:

Suggestions:

√ ***Attractive Colourful posters, pamphlet containing reproductive health messages should be displayed at the clinic***

√ ***Good Decorative will attract youth, plant tops, flower vase, etc.***

√ ***Entertainment arrangement such as games (carom board, VDO, etc.), film show on VCD/VDO, TV, Computer should be ensured at the clinics***

√ ***Enough sitting arrangement should be there at the waiting space***

√ ***Clean Toilet facility for females and males should be available***

√ ***Safe drinking water and glass should be available***

√ ***Health education during waiting time at the clinics***

4.5.4 Arrangement of the clinic

Most of the males and females in the FGDs stated that the clinic does not look like a clinic. The arrangement and setting need revision to attract youth.

4.5.5 4.4.5Privacy and confidentiality

There is strong agreement regarding the importance of privacy and confidentiality for the young reproductive health client[6]. Both male and female at the FGDs and in-depth interviews stressed their need for this issue. One of the male respondent said, 'I do not want to disclose my problems and even do not want other to know about it'. Privacy and confidentiality could be barrier for the youth to take services.

In a survey on serving young clients in Zimbabwe, although counselling usually occurred in a separate room, nearly one-fourth of the conversations could be overheard, outsiders could see what was happening in one-third of the sessions, and more than one-third experienced interruptions, usually by another staff member (Kim and Marangwanda, 1996).

Another aspect of confidentially involves record-keeping. Records of the youth should not be exposed to others or should not be discussed openly. The issue of privacy and confidentiality could be a reason for non-use of SDPs by the youth.

4.5.6 Provider Attitude

Young people are particularly sensitive to provider's attitude. Research indicates that the single most important barrier to care relates to providers' attitudes. In many societies and cultures, adults have difficulty in accepting teens' sexual development as a natural and positive part of growth and maturation. Young people are not encouraged to seek care if they encounter providers whose attitudes convey that youth should not be seeking sexual health services. Youth may reject health care services from the clinics[5]. Biases, judgmental attitudes, and, at times, even hostility on the part of service providers can create persistent and critical barriers to reproductive health services (Webb 1998). Judgmental teachers or health care workers can become barriers to services even where law and policy give adolescents access to reproductive health information and services[4]. Because health care workers often reflect the attitudes and values of their society, it is an important factor to consider for providing reproductive health services to youth.

Youth under study, in some cases, showed negative impression towards providers attitude. In one of the FGDs one participant mentioned of 'look down at the poor clients'. Another participants expressed her fearfulness and shakiness to speak with providers. Concern regarding provider attitude is a serious barrier in our country for youth friendly services.

In most of the areas need for trained providers has been reflected. They have also mentioned about support staff who should be trained to deal youth population.

4.5.7 Youth Participation

Youth can be involved at all stages of program development, implementation, and evaluation (Shah 1999). Both male and female youth in the study has expressed their willingness and ways to involve them in the program. Their suggestions are as follows:

- Encourage our friends and share our learning to our friends
- Participate in programs relating youth and initiate discussion on existing SRH program
- Accompany friends to visit SDPs and tell about services provided by SDPs

- Take active part in discussion with providers at the SDPs and share our perspective on improving services
- We could build teams for advocating parents.

A recent evaluation of nearly 500 organizations that implement reproductive health programs aimed at young adults throughout the world found that young people helped implement programs in almost 70 percent of cases (Herdman 1999). Involving adolescents can increase their sense of project ownership and relevance; improve recruitment and communication; generate new ideas for reaching other adolescents; and increase self-esteem and leadership skills (McCauley and Salter 1995; Senderowitz 1998).

Policy Implications:

- ***Clinics need rearrangement and modification to create youth friendly environment***
- ***Adequate time is needed for client and provider interactions***
- ***Adequate space and sufficient privacy need to be ensured***
- ***Comfortable surroundings ensuring adequate sitting arrangement, toilet facilities, air-circulation, drinking water, etc.***
- ***No overcrowding and short waiting time need to be managed***
- ***Education materials Vedio/computer games, television, film show***
- ***Youth should be involved in designing and continuing feed back***

5 CONCLUSION

The study has captured the expectations of the adolescents and youths on the one hand and the service providers on the other hand about adolescent friendly SRH services. The survey and FGD findings clearly provide a pen picture of the look, physical setting, providers' competencies and attitudes that would ensure adolescent friendly services particularly for the economically and socially backward segment of the population.

Survey findings have been well supported by the FGD results. These two sources of information have optimised the analysis and conclusion made in the report. Thus it is expected that the findings will provide significant insights and hands on road map toward policy formulation towards ensuring friendly SRH services. The report has provided the required policy inputs in the policy implication statements. It is expected that MSCS will transform the policy implications in the form guideline for adolescent friendly SRH services.

6 REFERENCES

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7 ANNEXES

ToR

Questionnaire

FGD Guide

Study Team