

Report for the Research Study titled

Understanding Social Norms Related to
Adolescent and Youth Sexual and Reproductive
Health and Rights (SRHR) in Bangladesh

To

Naripokkho

Submitted by

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Acronyms

BBS	Bangladesh Bureau of Statistics
CSE	Comprehensive Sexuality Education
FGD	Focused Group Discussion
FP	Family Planning
GO	Government Organisation
HIV	Human Immunodeficiency Viruses
IDI	In-depth Interviews
KII	Key Informant Interviews
GDC	Gender Diverse Communities
MHM	Menstrual Health Management
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
MVA	Manual Vacuum Aspiration
NCTB	National Curriculum and Textbook Board
NGO	Non-Government Organisation
Org	Organisation
RHRN	Right Here Right Now
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UN AIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1.1 Introduction

Adolescents and youth are vital to the advancement of nations, particularly in Bangladesh, where they represent a significant demographic. According to the Bangladesh Population Census 2022, nearly 52 million adolescents (ages 10-19) and youth (ages 20-29) comprise around one-third of the total population, with 19.92% adolescents and 17.79% youth in the country (BBS, 2022). This demographic holds immense potential to drive progress in various sectors, including education, economy, technology, and social development, positioning Bangladesh to harness a demographic dividend for its future growth (Patton et al., 2016).

However, despite the economic advancements and infrastructural developments in the country, serious challenges persist, particularly in the realm of sexual and reproductive health and rights (SRHR). Bangladesh has the highest child marriage rate in South Asia and ranks among the ten highest globally. Approximately 38 million girls marry before age 18, with 13 million marrying before age 15. Alarming, 59% of women aged 20 to 24 were married before 18, and 28% reported having been pregnant as adolescents (Lee et al., 2023).

The lack of attention to adolescents' and youth's understanding of SRHR remains a critical issue. The societal conservatism prevalent in Bangladesh creates a taboo around SRHR, leading to misinformation shaped by deeply ingrained beliefs and social norms (Marlow et al., 2016; Bohren et al., 2022; Islam et al., 2018). Social norms—defined as the unwritten rules that shape individual and group behaviour—play a significant role in influencing how adolescents and youth comprehend and navigate SRHR issues (Bicchieri, 2017; Petit, 2019; IPH, 2023). These norms often restrict access to information about family planning, menstrual regulation, and comprehensive sexuality education (CSE), making it difficult for young people to make informed decisions about their health, creating adverse health consequences.

Adolescents and youth face considerable barriers to accessing accurate information and SRH services, including contraception and CSE. Although some CSE components are included in high school curricula, they are often inadequately taught due to societal shame and conservatism, limiting adolescents' ability to make informed health decisions (Islam et al., 2018). Furthermore, parents often feel uncomfortable discussing SRH topics, fearing that they might reveal too much or encourage inappropriate behaviour (Bhuiyan, 2014; BIED, 2012; Rob et al., 2006).

This lack of knowledge and access, combined with pervasive misinformation, leaves young people grappling with confusion, excitement, fear, and curiosity about their bodies and health, while opportunities for reliable answers are scarce (Wynn et al., 2009). Addressing these gaps is crucial for empowering adolescents and youth in Bangladesh to navigate their sexual and reproductive health, remain well and healthy, and ultimately enable them to contribute effectively to the nation's development.

1.2 Literature review

1.2.1 Comprehensive Sexuality Education in Bangladesh: An overview

Comprehensive Sexuality Education (CSE) equips young people with the right knowledge, information and skills about sexuality, sexual and reproductive health, and rights using a rights-based curriculum, which helps them make informed, healthy and responsible choices critical to their physical, psychological and social well-being (WHO, 2023).

CSE encompasses a wide range of information and skills to help youth make informed choices about their SRH and understand their rights. By providing age-appropriate SRH knowledge and dispelling myths and taboos, adolescents and youth can access accurate information, necessary resources, and available services. This knowledge also helps them develop life skills such as critical thinking, building positive relationships, self-confidence, and effective decision-making. It also fosters self-awareness, responsibility, the ability to ask questions, seek help, and empathy in various situations (Braeken et al, 2010).

A standardised United Nations' Guidance on CSE was developed by the collaboration of UNESCO, UNFPA, UNICEF, UNWOMEN, UNAIDS and WHO (UNESCO, 2018). The purpose of the guidelines is to support education, health, and other relevant agencies in creating and implementing CSE programs and materials that can be used in schools and outside of them. This guideline also advised that the curriculum for CSE may be varied and should be adapted based on the cultural and religious contexts, social norms and practices of each country.

According to international guidance on CSE, the topics covered may be presented as 'life skills', 'family life education', 'health education' or other names considering social, cultural and religious contexts (WHO, 2023). The following table 1 shows the main concepts of CSE, recommended by the International Technical Guidance on Sexuality Education.

Table 1. Eight Key Concepts of Comprehensive Sexuality Education (UNESCO, 2018)

1. Relationships
2. Values, Rights, Culture and Sexuality
3. Understanding Gender
4. Violence and Staying Safe
5. Skills for Health and Wellbeing
6. The Human Body and Development
7. Sexual and Reproductive Health
8. Sexuality and Sexual Behaviour

CSE was introduced in Bangladesh to address adolescent health risks and promote informed decision-making. It was added to Bangladesh's curriculum in 2013 to help adolescents understand sexual health and support economic growth, however, there are still gaps in topics and all the CSE-related topics are not covered due to social and cultural resistance (Islam et al. 2018). Accessing quality education itself is a challenge in Bangladesh due to a lack of resources including trained teachers, cost of education, etc. Although CSE is a compulsory subject in the secondary school curriculum in Bangladesh, it is rarely taught in classrooms since the topics to be discussed and taught in classrooms are taboo because of cultural barriers and conservatism. There is a shortage of trained teachers with the right skills to teach these sensitive topics. Youth also do not know how and where to access the right knowledge. As such, youth grow up uninformed and lack the skills to navigate the complexities of SRHR issues and with the easy availability of the internet, adolescents and young adults now look for answers to their queries on various social media sites and porn sites (Janighorban et al., 2022).

To address this gap, the Government of the People's Republic of Bangladesh has undertaken a 14-year plan, “National Strategy for Adolescent Health 2017-2023” funded by UNFPA and UNICEF. The strategy has been planned and developed to achieve the sustainable development goal (SDG) 3 which is to ensure healthy life and well-being for all ages by the end of 2030. The government is aiming to create a socially secure and supportive environment for

adolescents to attain healthy and reproductive lives. This strategy developed and identified four thematic areas to promote adolescent health, including adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition, and the mental health of adolescents.

1.2.2 Family Planning in Bangladesh: An Overview

According to the World Health Organization (WHO), family planning (FP) is essential for individuals to determine how many children they want and when to have them, utilizing contraceptive methods and infertility treatments. Access to accurate information about contraception and available services is vital for safeguarding health and upholding human rights (WHO, 2024a).

The 2024 WHO report emphasises several critical benefits of family planning:

- Prevention of Unintended Pregnancies: FP reduces the incidence of unintended pregnancies, contributing to healthier mothers and lower pregnancy-related mortality rates.
- Empowerment of Young Women: It allows young girls to delay pregnancies, thereby minimising health risks associated with early childbirth.
- Support for Older Women: Older women can avoid complications related to pregnancies, promoting overall well-being.
- Reduction of Unsafe Abortions and STI Risks: By facilitating safer reproductive choices, FP helps decrease the rates of unsafe abortions and sexually transmitted infections (STIs), enabling girls to continue their education and women to engage more fully in society (WHO, 2024a).

Globally, nearly 923 million women wish to avoid or delay pregnancy, with approximately three-quarters currently using modern contraceptive methods (USAID, 2023). The 2030 Agenda for Sustainable Development, specifically SDG Target 3.7, calls for universal access to sexual and reproductive health care services, including family planning, by 2030 (UN, 2015).

In South Asia, the use of modern contraception remains low, with a median contraceptive prevalence rate (CPR) of just 37% and an unmet need for contraception reaching 12% (Pradhan & Mondal, 2023). In Bangladesh, which faces a significant population challenge with a density

of 1,179 people per square kilometre, family planning initiatives have been in place since the early 1950s, culminating in a formal program established between 1965 and 1995. The national FP program, launched in the mid-1970s, focuses on collaboration and outreach efforts (Ministry of Health and Family Welfare, 2014).

Despite being a Muslim-majority country with diverse cultural contexts, Bangladesh has made strides in managing population growth. As of 2022, the total fertility rate (TFR) stands at 2.3 children per woman, with a contraceptive prevalence rate (CPR) of 64% among currently married women aged 15–49. Modern contraceptive methods are utilised by 55% of this demographic, with oral contraceptive pills being the most common method at 27%. The aim is to achieve a CPR of 75% by 2023. Although there has been an increase in modern contraceptive use from 52% to 55% between 2017–18 and 2022, significant challenges remain (NIPORT & IFC, 2022).

Research indicates a rising trend in contraceptive use, particularly among married women in Bangladesh, who show a preference for short-acting methods (Huda et al., 2017). Additionally, the Demographic and Health Survey (DHS) across four South Asian countries suggests that women living with their mothers-in-law are more likely to use birth control for spacing pregnancies (Pradhan, 2023). However, existing studies often exclude unmarried women, leaving critical gaps in addressing the issue of unmarried pregnancies.

Addressing the societal norms and existing barriers that hinder the universal acceptance of family planning is crucial for further advancing reproductive health in Bangladesh. By enhancing access to information and services, the country can empower individuals to make informed choices about their reproductive health, contributing to overall societal progress.

The age gap between husbands and wives significantly influences early motherhood in Bangladesh. Research indicates that when wives are closer to 30 years of age, they often feel pressured to conceive soon after marriage due to fears of infertility. In fact, the average age difference between husbands and wives in Bangladesh is about 8.5 years, as reported by the Bangladesh Demographic Health Survey 2017-18 (NIPORT, 2019). This spousal age gap is a crucial predictor of pregnancy timing and motherhood.

Several studies highlight the relationship between spousal age difference and reproductive health outcomes:



- **Teenage Pregnancy Risk:** A study found that teenage girls with smaller age gaps (less than five years) face a 55.3% lower risk of becoming adolescent mothers (Islam, 2017). Conversely, larger age gaps often correlate with higher odds of early motherhood and complicate contraceptive use and reproductive health decision-making.
- **Decision-Making Dynamics:** In relationships with wider age gaps, husbands tend to dominate decision-making, including matters related to contraception and pregnancy choices. A 2021 study demonstrated that a greater spousal age difference is linked to an increased likelihood of early motherhood (Karim, 2021).
- **Fertility Risks:** Research also indicates that a higher age difference can elevate fertility risks, making younger wives more vulnerable to reproductive health complications (Uddin, 2013).

Teenage Pregnancy Rates in Bangladesh

Teenage pregnancy remains a significant concern in Bangladesh. According to the Bangladesh DHS 2022, 23.7% of married women aged 15–19 have experienced pregnancy, with contraceptive use among this demographic at only 53.9% (NIPORT & IFC, 2023).

Several factors contribute to this high rate:

- **Economic Pressures:** Unemployment and financial dependence on parents can influence young couples' decisions about family planning.
- **Influence of Mothers-in-Law:** Mothers-in-law often play a crucial role in contraceptive decision-making, which can limit the autonomy of younger wives.
- **Lack of Reproductive Health Knowledge:** Many adolescents lack access to comprehensive reproductive health education, hindering their ability to make informed choices.
- **Communication Barriers:** Negotiation and communication challenges between partners can prevent effective discussions about contraception and family planning.
- **Cultural Pressures:** There is often societal pressure and expectations for newly married women to conceive within the first year of marriage, contributing to early childbearing.
- **Mistrust in Contraceptive Methods:** A lack of trust in contraceptive options can lead to hesitancy in using them, further increasing the risk of unintended pregnancies (Samandari et al., 2020).

Addressing the complex interplay of spousal age gaps, economic pressures, and cultural norms is essential for reducing adolescent pregnancy rates in Bangladesh. Empowering young women with education about reproductive health and increasing their access to contraceptive methods can help them make informed choices, ultimately improving their health outcomes and overall well-being.

1.2.3 Menstrual Regulation in Bangladesh: An Overview

Menstrual Regulation (MR) is a medical procedure that helps regulate the menstrual cycle. MR is different from induced abortion and is typically performed during the early stages of pregnancy, within twelve weeks from the first day of the last menstrual period. According to the World Health Organization (WHO), MR is a process of uterine evacuation that does not require laboratory or ultrasound confirmation of pregnancy. It is performed for women who report recently delayed menses (WHO Report on Safe Abortion, 2012). The WHO (2012) report estimated that 46 million pregnancies ended up in abortion each year globally, and 22 million were estimated as unsafe abortions. The WHO Report also shows that one in five women suffers serious infections and other health problems after an unsafe abortion. In many countries, the laws permit abortion only to save a woman's life and it is therefore ironic that women are allowed to die of unsafe abortion. In developing countries, the risk of death from unsafe abortion procedures is hundreds of times higher than the risk of abortion under safe procedures (WHO. 2012).

In Bangladesh, according to the Penal Code of 1860, abortion is allowed solely to save a woman's life and since 1979, MR has been formulated as part of the FP Service Programme, which states that MR can be done up to 10-12 weeks from the first day of the last menstrual period (Ministry of Health and Family Welfare. 2023). MR can be performed by any registered and trained doctor or medical practitioner including midwives, nurses and any other medical personnel who has received specific training, for 18 months on MR procedures from any government-recognised MR clinic in the country. In Bangladesh, MR services have been targeted towards married women and research on unmarried girls undergoing MR is limited so it is challenging to find any exact data on this. According to a study from 19 years ago, published in 2005, the performing MR of unmarried adolescents is 35 times higher than that of married adolescents due to social stigma and taboo.

In 2014, around 1.2 million abortions happened in Bangladesh, with 29 per 1,000 women aged 15-49 years, and 257,000-women seeking treatment for abortion complications, at a rate of 6 per 1,000 women aged 15-49 (Singh et al., 2017). (The number of MR procedures dropped by 40%, from 17 to 10 per 1,000 women aged 15–49, between 2010 and 2014 (Singh et al., 2017). In addition to MR provided surgically, MR with medication (MRM) was introduced in Bangladesh to use from 2014 with the two drugs mifepristone-misoprostol (Marlow et al., 2015) (Ministry of Health and Family Welfare. 2023).

1.3 A short description of the RHRN programme

The Right Here Right Now (RHRN) Project is funded by the Ministry of Foreign Affairs of the Netherlands, through the Netherlands based organisation Rutgers. The project is a five-year, 2020-2025, global strategic partnership. This is the 2nd phase of the project which envisions that youth in all their diversity enjoy their sexual and reproductive health and rights in gender-just societies. The programme lobbies governments to adopt and be accountable for inclusive human rights-based policies and laws which ensures SRHR and gender justice for the adolescents and youth of Bangladesh. The Bangladesh coalition consists of 7 partner organisations. They are conducting their programme activities in 25 districts of Bangladesh (Table 2). Here Org A is leading the coalition.

Table 2. Institution wise program activities locations.

	Implementing organisations				
	Organisation A (Org A)	Organisation B (Org B)	Organisation C (Org C)	Organisation D (Org D)	Organisation E (Org E)
Districts	Rangpur Lalmonirhat Joypurhat Naogaon Jamalpur Mymensingh Hobiganj Khulna Bagerhat	Kushtia Moulvibazar Netrokona Barishal Patuakhali Barguna Jhalokathi Bhola Rangamati	Dhaka	Savar Narail Sylhet Gaibandha	Dhaka Narayangan j

1.4 Development of the Study Proposal

Org B, a partner in the RHRN2 coalition in Bangladesh, commissioned the BRAC James P. Grant School of Public Health (BRAC JPGSPH) at BRAC University to conduct this study. After initial consultations with Org B, BRAC JPGSPH drafted a study proposal, which underwent review by various Bangladesh RHRN2 partner organisations and experts from Rutgers in the Netherlands.

The methodology was refined based on the valuable feedback and suggestions provided by the Rutgers experts and coalition partners in Bangladesh. Following these revisions, the study proposal was granted ethical approval by the Institutional Review Board of BRAC JPGSPH, ensuring that it met the necessary ethical standards for research.

1.5 Study Objectives

The study objectives are-

1. To understand the existing social norms, values, and attitudes related to adolescent and youth SRHR, focusing on family planning methods, MR, and comprehensive sexuality education.
2. To understand how these norms influence practices and behaviour of adolescents and youth.
3. To provide recommendations for designing programme activities for changing harmful social norms and practices.

2. Methodology

2.1 Design and approach of the research

This research followed exploratory and qualitative approaches to reach the objectives. An initial desk review was performed to understand the current and available evidence and information on the research objectives. It also helped to construct qualitative tools for primary data collection.

The research objectives were set based on the RHRN2 programme needs. Three main topics were identified: CSE, FP and MR. These were set through discussions with RHRN2

programme-implementing organisations as their programme activities are focused on these topics.

2.2 Study areas

The RHRN2 programme is currently being implemented in 25 districts across Bangladesh by six organisations. To align with program needs and consider time and resource constraints, six districts were purposefully selected for data collection, following consultations with the implementing organisations.

The selected districts—Bhola, Moulvibazar, Rangamati, Khulna, Gaibandha, and Dhaka—represent different geographical regions of the country. As indicated in Table 2, RHRN2 programme partners are active in these areas. For data collection, one upazila (sub-district) was chosen from each selected district. Data were gathered from the main upazila and district towns, representing urban areas, as well as from the interior regions of the upazila to ensure a comprehensive understanding of both rural and urban contexts.

Table 3 shows the organisations and their relevant intervention areas from where data were collected. Figure 1 describes the research study sites where data were collected from.

Table 3. Programme implementing organisation and working areas

Programme implementing organisation	Districts	Upazila/ward
Org B	Bhola	Bhola Sadar
Org B	Moulvibazar	Sreemangal
Org B	Rangamati	Rangamati Sadar
Org A	Khulna	Dumuria
Org D	Gaibandha	Gaibandha Sadar
Org D	Dhaka	Ward 17, Dhaka north city corporation

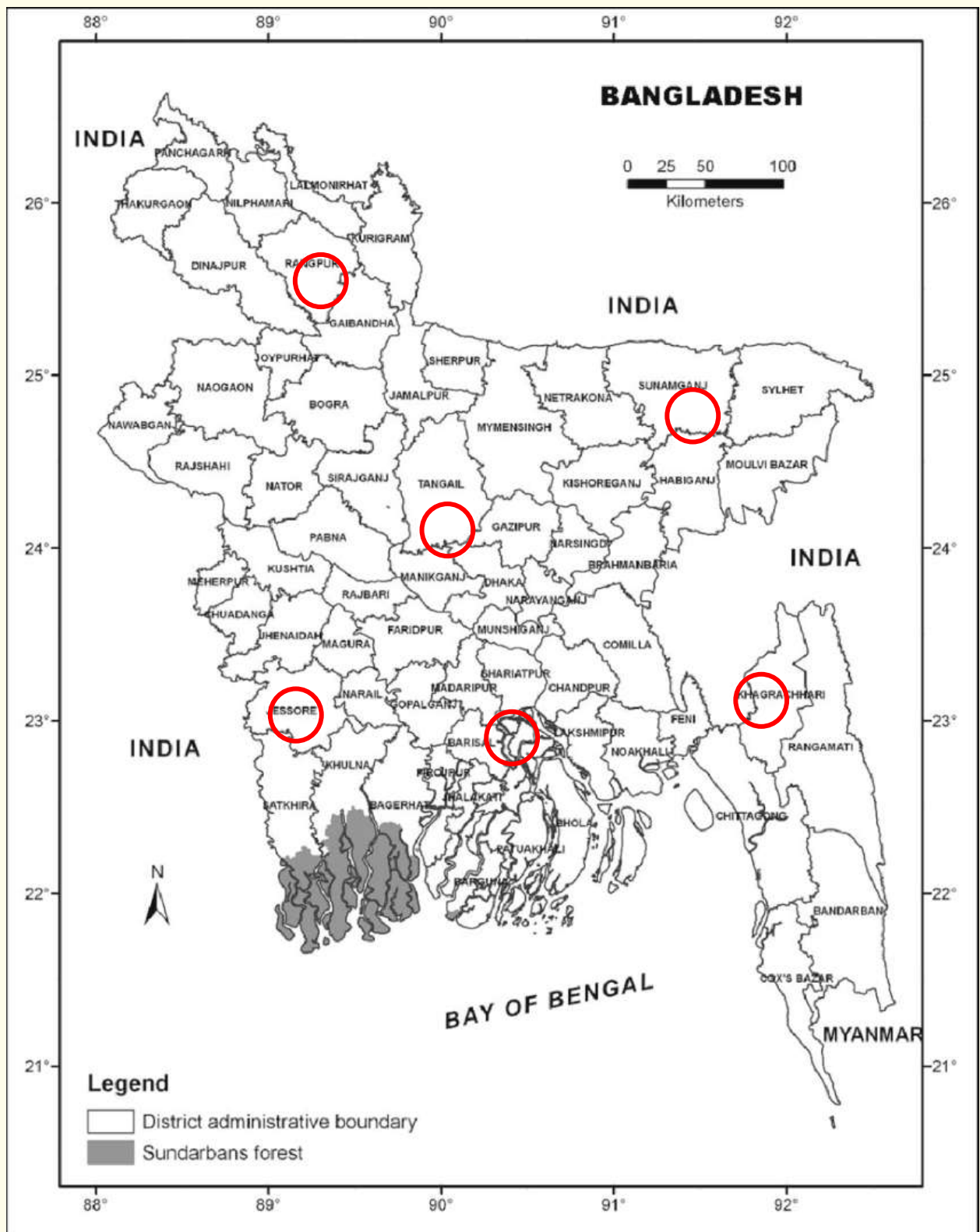


Figure 1. Map showing the study sites

2.3 Study respondents and sample size

In this study, the primary target population consists of adolescents, youth, and gender-diverse individuals aged 15-30 years, aligning with the objectives of the RHRN2 project. Here's how the sample was structured:

- Adolescents: Individuals under 18 years of age.
- Youth: Those who are 18 years or older.
- Socio-economic diversity: Respondents were selected from various socio-economic backgrounds.
- Ethnic minorities were specifically sampled in Rangamati (Org B's working area).
- Gender-diverse individuals were sampled in Dhaka. The respondents from gender-diverse communities for this study, are referred to as males or females based on the male or female bodies they possess.

This approach ensures inclusivity while maintaining privacy and confidentiality.

This demographic data presents a rich diversity across different regions in Bangladesh:

- 1.Gaibandha, Bhola, Khulna, and Dhaka: The majority of respondents were Muslim and part of the mainstream Bengali community
- 2.Sreemangal: The majority were Hindu and Sanatan, with only a few Muslims. Respondents belonged to various ethnic groups, including Tati, Ganju, Kurmi, Chashi, Modi, Sabal, Bin, Munda, Santal, and Koiri.
3. Rangamati: All respondents were Buddhist, with Chakma, Marma, and Tanchyanga being the prominent ethnic groups.

This variety underscores the religious and ethnic diversity in different parts of Bangladesh, especially highlighting how the indigenous populations in Sreemangal and Rangamati differ significantly from the mainstream populations in other regions.

The secondary target groups were socially influential members, community leaders, faith leaders, school teachers, parents of adolescents and spouses, youth leaders, and programme people who are associated with RHRN2 from the respective areas. We collected information

from both urban and rural sites in each area except Dhaka. For example, we collected data from Bhola and Khulna, as well as the rural areas of Bhola and Dumuria in Khulna.

2.4 Recruitment of study respondents, sample size and settings of data collection

Six implementation partner organisations of the RHRN2 programme have local offices in their respective intervention areas. We took support from the staff of these local offices to identify, select and reach out to potential study respondents from the RHRN2 intervention catchment areas from different sites. Thus, purposive selection was carried out based on the inclusion criteria. The inclusion criteria were presented in Table 4.

Table 4. Inclusion criteria of the respondents

Respondents	Inclusion criteria
Adolescent	Aged less than 18 years (15-17 year)
Youth	Aged 18 years or more (18-30 year)
Parents	Parents of adolescents or youth
Local influentials	Locally influential people, community leaders, political leaders
Programme people	Programme personnel who are associated with RHRN2 programmes
Youth leader	Youth leader/volunteers who are associated with RHRN2 programme
Teacher	Teachers of high school who teach physical education/health education
Religious leader	From different religion, mainly from Islam, Buddhist, Hindu, Christian

Based on the inclusion criteria, we requested local RHRN2 staff to list potential respondents, from which the respondents were selected.

Sample size

Initially, we planned to collect a total of 36 interviews from six different areas. However, during data collection in the field sites, researchers found some additional references of respondents from IDI, FGD and KII respondents who were also approached. Therefore, a total of 78 interviews were conducted and 23 written case stories were collected.

Table 5 shows that a total (77 interviews) 25 Focus-Group Discussions (FGDs), 21 IDIs, and 32 Key Informant Interviews (KIIs) were conducted to collect qualitative data. Along with these, we also collected 23 written case stories on particular issues from FGD respondents.

Table 5. Sample size and different categories of respondents

One upazila from District	FGDs (M=Male; F=Female)		IDIs (M=Male; F=Female)		Case story	KIIs
	Age 15-17	Age 18-30	Age 15-17	Age 18-30		
Bhola	F (1) M (1)	F (1) M (1)		F (2) M (1)	F(8)	Teacher (2) Youth leader (2) Parent (1) Religious leader (1)
Moulavibazar	F (2) M (2)	F (2) M (2)	F (1) M (1)	F (1) M (1)	F(4)	Parent (1) Teacher (1) Local influential person (2) Youth leader (1)
Khulna	F (1) M (1)	F (1) M (1)	F (1) M (1)	F (1) M (1)		Parent (1) Teacher (1) Programme people (1) Health worker (1)
Gaibandha	F (1) M (1)	F (1) M (1)	F (1) M (1)	F (1) M (1)	F (5) M (4)	Teacher (1) Programme people (1) Faith leader (1) Local influential person (1) Parent (1) Religious leader (1)
Rangamati	Ethnic Male (1) Ethnic Female (1)	Ethnic Male (1) Ethnic Female (1)		F (3) M (1)	F (2)	Local influential person (1) Teacher (3) Faith leader (1) Programme people (2) Youth leader (3)
Dhaka		Gender Diverse group (1)		Trans (2)		Programme people (1)
Total	12+13=25		6+15=21		23	32

The above table (Table 5) also shows that among 25 FDGs, 12 were with adolescents aged 15 to 17 years (6 with males and 6 with females) and 13 were with youth aged 18-30 years (6 with males, 6 with females and 1 was with gender diverse population). Among 21 IDIs, 6 were with the age group of 15-17 years and the rest 15 were with the youth group, aged 18-30 years. During FGD sessions, the researchers asked some of the selective respondents to write down some cases they experienced in their life, in particular one issue which was related to CSE, FP or MR. Among 23 case stories, 19 were from females and 4 from males. We conducted 32 KIIs in total: with teachers (8), youth leaders (7), local influential people (4), parents (4), faith leaders (3), programme people (5) and health workers (1). There were six to eight respondents in each FGD session.

The RHRN2 field staff from implementing organisations also supported arranging the interview sessions and reaching the respondents. Data collection places and times were set based on the respondent's convenience and preferences. We conducted interviews in the respondent's local areas as well as in the local partner offices.

2.5 Methods of data collection

The study design was qualitative and used focus group discussions (FGDs), In-depth Interviews (IDIs), and key informant interviews (KIIs) as well as case stories. With adolescents and youth FDGs, IDIs were conducted and case stories collected. With community leaders and socially influential members, faith leaders, school teachers, youth leaders, parents of the youths and programme people, KIIs were conducted.

Social norms are collective issues, and they influence individuals and community practices. Therefore, in the first step, we conducted FGDs to explore and understand perception, belief, attitude practice and underlying reasons present in the community, which significantly influence collective and individual practices around the three targeted topics (CSE, FP, MR). For conducting the FGDs, we used an adapted Social Norms Exploration Tool (SNET) framework (IRH, 2020). The SNET framework is a participatory method that guides exploring social norms through participatory focus group discussion. We explored social norms around the targeted issues from these FGDs and collective opinions about the underlying reasons, and practices influenced by these norms. These FGDs also helped to identify people who influence behaviour.

For identifying and exploring individual experiences, opinions or practices, we collected written case stories from selected FGD respondents.

After conducting FGDs in the particular study sites, the research team conducted a debriefing session to analyse the initial FGD findings which allowed the team to identify perceptions, beliefs, attitudes, practices and underlying reasons of these practices, to help identify social norms around the targeted topics.

We then conducted IDIs to explore and understand the individual perceptions, attitudes, beliefs, practices, and factors influencing their behaviours and social norms.

After conducting FGDs and IDIs, we conducted KIIs. The Key-Informant Interviews helped us to explore the overall scenario of the community understanding and practices on the issues related to the study objectives. Through KIIs with programme people information on existing programme activities and opinions and ideas about what necessary actions are required for positive changes were gathered.

Separate qualitative guidelines (for FGDs, case stories, IDIs and KIIs for every target audience) for each data collection method were developed.

2.6 Data collection process

A group of experienced and trained researchers collected qualitative data using various tools (IDI, FGD and KII tools) for different data collection methods (Annexure 1). These tools were pretested and modified based on the pretest experiences. The researchers went through several rounds of rigorous training before conducting the field interviews. Face-to-face interviews/sessions were conducted with respondents. All ethical issues were strictly maintained as discussed in section 3.8.

Two researchers in a group conducted FGDs. Male data collectors collected data from male respondents, and female researchers collected data from female respondents. After an FGD session, some selected FGD respondents were asked to share a written case story on assigned issues.

The duration of data collection was from 10 October to December 20, 2023. The interview duration for FGDs was around 120-150 minutes, and IDI and KII were approximately 50-100 minutes. All discussions and interviews were conducted in Bangla.

2.7 Data analysis

An outline of the analysis plan was prepared before analysing the data following a framework proposed by Gale et al (2013). All interviews were transcribed by experienced transcribers. A rigorous process of data familiarisation took place; this involved reading the transcripts repeatedly to ascertain emerging themes. A prior code list was prepared and emerging codes were identified during data coding and added to the previously developed code list. All data were coded using MAXQDA (Version 12) software. All researchers participated in training on MAXQDA coding before starting coding.

After coding the transcripts, all coded data were merged into a data matrix to help identify the themes and types of information and compare and cross-check among and between respondents and data collection sites. The information from multiple data sources, including geographical areas, FGDs, IDIs, KIIs and case stories of the different respondent categories, were used to triangulate the data. After that, a thematic analysis was performed to summarise the findings. We will use Heise & Manji's (2018) proposed Ecological Framework to analyse social norms' influences on practice and behaviour. The analysis went through several rounds of review by senior researchers and applied in all aspects of data analysis. A draft report was shared with Org B and their expert feedback was collected and incorporated into the final report.

2.8 Ethical procedure

Written informed consent was obtained from all the FGD, IDI and KII respondents (Annexure 2). The study obtained approval from the Institutional Review Board of the BRAC James P. Grant School of Public Health, BRAC University.

The informed consent had an information sheet that contained the name of the project, the organisation and researchers involved in this research, and the respondent's demographic information, contact information of respondents and researchers, as well as the research-implementing organisation. It also included the contact address of the Institutional Review Board of the BRAC James P. Grant School of Public Health, BRAC University, if respondents needed further clarification.

The consent form provided information on the purpose of the project, the interview process, the interview duration, processes for maintaining anonymity, confidentiality, volunteer participation, risks, and benefits, as well as the rights to withdraw from the interviews.

All interview conversations were audio-recorded with the respondent's permission. We clearly explained the purpose of recording the interview conversation and asked the respondent's permission to record.

The study recruited adolescents (under 18) and for this, the researchers obtained consent from their respective parents/guardians and, after that, received assent from <18-year aged respondents. After receiving consent, the researchers proceeded to interviews. One copy of the project information sheet and the researcher's contact numbers and IRB were provided to the respondents.

The data are stored in an authorised and password-protected Google cloud store and only authorised researchers have access to these data.

3. Limitations of the study

Language used by respondents: All interviews for the study were conducted in Bengali, even for the ethnic minority groups in Rangamati. Care was taken to ensure that all respondents recruited could understand and speak Bengali fluently, and it was found that all respondents from Rangamati had a good command of the language.

However, one interview with a faith leader in Rangamati required more attention, as the respondent used a mix of Bangla, Marma and the Chittagong dialect during the conversation. This interview was transcribed by a local transcriber familiar with all three languages and dialects. This underscores the linguistic diversity in the region, while also showing that Bengali remains a common means of communication for these ethnic minority groups.

Short study duration: The study was conducted within a very short timeframe, requiring data collection from diverse geographic locations and cultural groups. To meet these challenges without compromising the quality of the research, the team employed more researchers to ensure timely data collection. Additionally, RHRN2 coalition partners provided valuable support by helping to identify and select potential respondents, which contributed to the smooth execution of the study despite the time constraints.

This collaborative effort ensured that the study maintained its rigour while covering a broad range of respondents efficiently.

Hesitation to talk about sensitive issues: Some respondents were hesitant to discuss sensitive topics, such as their sexuality, sexual life, personal practices, and family-related matters, primarily due to fear of judgement and social stigma. This reluctance was a significant challenge in the study. The limited timeframe also made it difficult to build a strong rapport with respondents, which could have helped ease their discomfort and encouraged more open conversations.

A longer engagement period might have helped to establish trust and create a safer space for respondents to share these intimate details, potentially yielding deeper insights into these sensitive areas.

Selection bias: With time limitation, the reliance on staff of RHRN2 implementing organisations to help select respondents could have led to biases as those who are exposed to interventions had better knowledge, and their perceptions and attitudes also differed from those of non-exposed respondents. Therefore, the information obtained may not always provide the actual scenario. Furthermore, for selecting respondents from gender diverse communities (GDC), we had to seek support from RHRN2 implementing organisations. We found the respondents had some level of training or workshops exposure on the issues of SRHR. So, there may have been some biases in generalisation of findings as the respondents had better knowledge compared to others who had no exposure.

Limited time for data analysis: Time was limited for analysing data. However, given the expertise and experience of BRAC JPGSPH, its research team was capable and had the experience to work in such a short period.

Terminology: In the description of Menstruation Regulation (MR), medical menstrual regulation (MRM) and manual vacuum aspiration (MVA) are not differently addressed, rather, we used MR to refer to both terms.

4. Findings

The study collected data from six different areas of Bangladesh to understand the social norms, values, attitudes and practices related to CSE, FP, MHM, and MR as shared by adolescent and youth males and females, their parents, community influential people, teachers, faith leaders, development programme personnel. This report presents the findings in three sections. The first section discusses knowledge, attitude, beliefs and social norms and its influences on practices related to CSE. The following sections describe FP and MR related issues respectively. After each section, we also provided a list of key findings in each section.

4.1 Comprehensive Sexuality Education (CSE)

This section describes knowledge and perception about CSE among adolescents and youth. It also describes the attitude, beliefs and social norms associated with CSE and how these influence CSE implementation in the study areas.

4.1.1 Knowledge and perception regarding CSE

Among the three main components of this study, one focuses on Comprehensive Sexuality Education (CSE) and its potential to empower young people, thereby enhancing their health and overall well-being. To achieve this, the study examines the perceptions, knowledge, attitudes, and practices related to CSE among adolescents, youth, parents, teachers, and community members across all six study sites.

Knowledge and perception regarding CSE among adolescent and youth. The research found that most adolescent and youth respondents (aged 13 to 30) across all study areas—except in Dhaka—were not familiar with the term 'CSE.' They were unsure whether it was included in their high school curriculum, and many stated that they had never heard the term before or read any related materials. Although 'CSE' was frequently mentioned, students generally did not understand its meaning, were unaware of its inclusion in their curriculum, and did not know which topics it covered.

During these discussions, numerous adolescents and youth asked the researchers to explain what CSE actually involved. After the researchers clarified the acronym 'CSE' and explained the topics it covered—such as puberty, menstruation, contraception, menstrual health management, HIV, early marriage, and reproduction—some students in classes 6 to 10 recalled

having a '*shasthyo-shurokkhya boi*' (wellbeing book) where these subjects were mentioned. However, apart from adolescents in one tea garden in Sreemangal and one community in Gaibandha, all of the students stated that these chapters were neither taught in their classrooms nor included in their examination syllabus. As a result, they did not pay attention to this material.

The findings highlight that while the term 'CSE' was commonly used, most students did not understand what it meant, nor did they realise that it was part of their curriculum. They also failed to recognise that the topics in their health care books—such as menstrual health management, hygiene, early marriage, reproduction, and HIV—were actually elements of the CSE curriculum.

Rather, when they heard the full name of CSE, they thought it was mainly about adolescence and sexual relationships since the word "sexuality" was there. Their teachers did not teach them these topics in class either, and most of the time skipped the chapters and asked them to read these topics at home.

Beyond their school textbooks, adolescents and youth primarily obtain information from their peers or the internet. Notably, none of the respondents reported receiving any information from healthcare workers specifically on CSE or puberty. Only married girls received some family planning information, which was provided during pregnancy and delivery.

Only a few girls mentioned receiving information from family members such as mothers or older female siblings. A lot of the time, young girls seek information and guidance from female neighbours. In the Sreemangal tea gardens, for example, girls often turn to a local 'Boudi' (sister-in-law) for information. Although 'Boudi' may not be their own brother's wife, she holds a sister-in-law-like role within the community and serves as a trusted confidante. When girls need information, support, or services related to CSE and SRH, they approach the *Boudi* for help. The following case (Case 1) illustrates the critical role that these *Boudis* play in informing and supporting girls on matters of CSE and SRH in the tea garden areas.



Case 1

In the Sreemangal tea garden area of Bangladesh, adolescents and youth face significant challenges in accessing education, healthcare, and information about sexual and reproductive health and rights (SRHR). Due to limited infrastructure, scarce health services, and early school dropouts, young people often turn to trusted community figures for guidance. Among these, the role of "*Boudi*" (sister-in-law) emerges as a critical informal support system for young girls. Being a young married woman within the community, closer to the age of adolescent girls and boys, *Boudi* is experienced and can provide the information and support they need regarding their personal matters.

Most boys and girls in the tea garden communities drop out of school after entering high school due to limited educational facilities, financial constraints, and the long distances between home and school. This lack of formal education deprives adolescents of essential SRHR information typically provided in school settings. Healthcare access is also severely restricted. Poor transportation and communication infrastructure discourage healthcare providers from visiting these remote areas. Consequently, local drug sellers and trusted neighbours become primary sources of health-related information and support.

In the Sreemangal tea garden communities revealed that many young girls seek advice from their *Boudi*, with whom they are very close. Adolescent girls stay home after dropping out of school to look after their younger siblings and do the household chores as their parents work in the tea gardens. In tea gardens, Hindu parents and communities strictly limit marriages to the same caste and class, making it challenging to find suitable husbands for girls within the same garden. This results in delayed marriages for adolescents and young girls compared to other communities. We found girls who were not married till the age of 22, 23, 24, etc. For these girls, *Boudi* is a major support. As they stay at home unsupervised and have ample time to spend, adolescent and young girls get involved in romantic relationships and engage in premarital sexual relationships. For such cases, the girl and the boy need alibis, safe spaces to meet and advise. *Boudis* in these cases were found to be playing critical roles. Girls frequently consult *Boudi* about menstrual health management, puberty-related changes, and SRHR issues they encounter. Since conversations about these



topics with parents or teachers are rare, *Boudi* becomes a reliable confidant and has a very close and friendly relationship with young females in this community. One of the young females in the FGD mentioned that when they face issues like menstrual problems or problems in romantic relationships, they go to this Boudi. ask for her suggestions on how to manage these problems, and Boudi guides them on the best course of action.

As romantic relationships are common among adolescents in the tea garden areas. Girls mostly seek *Boudi*'s advice on managing their romantic relationships, dealing with emotional issues, and making decisions about sexual activity. Discussions about contraception are not openly addressed in the community. However, *Boudi* plays a discreet but essential role in advising on contraceptive use, including oral pills, condoms, and emergency contraceptives. In one incident shared by a young girl during an in-depth interview that one of her friends was in a romantic relationship. After having sexual intercourse with her boyfriend, she feared she might be pregnant. She sought advice from Boudi, who recommended taking an emergency contraceptive pill. Then her friend took the pill and felt relieved.

In cases of fear of unintended pregnancies, girls are informed they resort to seeking help and advice from the *Boudi*. She guides them and sometimes connects them with trusted traditional healers (kaboraj) who ensure privacy and confidentiality to conduct informal and often risky menstrual regulation (MR) services.

The reliance on *Boudi* underscores the cultural dynamics of the tea garden communities, where social norms often hinder open discussions about SRHR. In this context, *Boudi* serves as a bridge between traditional values and modern health needs. Her role highlights the importance of community-based support systems, especially in regions with limited formal healthcare and educational services.

Boudi's role in the Sreemangal tea garden area illustrates an adaptive, culturally rooted support system addressing critical gaps in SRHR information and services. *Boudi* has earned the trust of younger girls through her supportive and non-judgmental attitude. Recognising and integrating such informal community networks into broader health and education programmes could enhance the well-being of adolescents and youth in underserved areas.

Knowledge and perception regarding CSE among parents and community peoples

Parents and community members also stated that they had never heard of the term 'CSE' and were unfamiliar with its curriculum and topics. After the full name of CSE was explained, many parents, community members, adolescents, and youth tended to interpret it primarily as 'teaching about sexual relationships' or 'education on sex and sexual relations,' likely due to the emphasis on 'sexuality education.' As a result, the term 'sexuality education' alone often creates a misleading impression within the community. One KII from Gaibandha, therefore suggested-

“This term ‘Sexuality Education’ creates the main problem, if we use ‘health education’ or something else for adolescents and youth and include texts that are in the book, they may not face such resistance. . NCTB also changed the name of the book in secondary level now, probably. . . shasthyo-shurokkhya” (KII, high school teacher, Gaibandha)

In the school textbooks, the term "CSE" is not explicitly used; instead, the book is titled ‘*Shasthyo Shurokkha*’, which includes information related to SRHR, along with puberty, menstrual hygiene management, etc. However, parents and community members perceive these books and teachers as providing "sexuality education" to their children.

In most schools, physical education teachers—who are predominantly male—are responsible for teaching this subject beginning in Grade 6. While these teachers generally understand the topics and have received government training, they face significant challenges in the classroom, mainly due to (1) the social stigma and taboos associated with such subjects, which often lead to feelings of shame, and (2) fear of backlash from parents and the wider community. Additionally, the co-educational setup of the classes presents another hurdle, as both female and male students tend to feel uncomfortable discussing these topics together, particularly when the instructor is male.

In the Rangamati and Gaibandha areas, researchers identified a few exceptional teachers who took the initiative to separate boys and girls during CSE sessions. This approach helped create a more comfortable environment for students, and, according to these teachers, both male and female students showed a solid understanding and awareness of the CSE topics covered.

Interestingly, madrasa teachers reported that madrasa curriculum already includes similar topics—emphasizing on maintenance of hygiene, abstinence before marriage, restrictions on extramarital relationships and discouraging unrestricted interaction between genders to uphold moral values. This foundation equips educators with a deeper understanding of these issues

The KII respondents, who were programme staff working on SRHR and CSE initiatives for the last 5-8 years, reported being familiar with CSE. They were involved in various SRHR and CSE-focused programmes and knew about related frameworks. Some young girls and boys participating in youth clubs, volunteer networks, and similar programmes also learned about certain health topics; however, they did not realise these subjects were part of the broader CSE framework.

An exception was found in the Dhaka study area, where FGDs and IDIs were conducted with gender-diverse youth (including both males and females). These respondents demonstrated a partial understanding of CSE, though they were not fully aware of all the topics it encompassed. However, their understanding is better compared to other areas. One respondent added-

“CSE is a vast area, it includes SRHR, gender, sex, sexuality, contraception, reproduction, pregnancy, romantic relationships and many other things. . .we know it from here (the organisation he was involved with)”. (Youth Male, age 23, Dhaka)

This is likely because they have achieved higher levels of education compared to respondents in the other five study areas, and some have experience working on SRH-related issues. Most of them have participated in volunteer work or attended training and workshops covering various SRHR topics. One individual, who had not acquired this knowledge through any formal programmes or volunteer activities, explained that he learned about these issues through private tutoring, while teaching students at the secondary level.

Overall, the findings reveal a considerable gap in awareness and comprehension of CSE among adolescents, youth, parents, and community members across the study sites. The specific use of the term 'sexuality education' has contributed to misunderstandings, making it more challenging for communities to accept and effectively implement CSE initiatives.



4.1.2 Attitudes, beliefs and social norms regarding CSE

The term 'CSE' is frequently misunderstood, with its emphasis on 'sexuality' often leading to a negative perception among adolescent and youth respondents, as well as parents and other community members. Many perceive CSE as secretive, inappropriate, or taboo, influenced by religious conservatism and prevailing social beliefs. Consequently, data from IDIs, FGDs, and KIIs indicate that CSE is not widely accepted from a social or religious standpoint.

Some teachers and programme staff, despite not having a comprehensive understanding of CSE, acknowledged its importance in topics of puberty and physical development. They believed, however, that it should be confined to topics such as puberty and physical development. Broadening the conversation to include other aspects of sexual health, they feared, would provoke resistance from community members, parents, and religious leaders.

All study respondents noted restrictions and reluctance in openly discussing CSE-related issues. Consequently, it has become a common norm to avoid such topics openly or in classroom settings, as doing so is perceived as undermining social values. A key informant, who worked as a programme officer at a local development organisation in Gaibandha for 28 years, emphasised this sentiment. His experiences reflect the deep-rooted cultural resistance to openly addressing sexual health, indicating that CSE remains a controversial subject in many communities.

"In our society, people are not yet ready to talk about the sexual and reproductive health of adolescents and youth. They do not prefer it to be discussed in the public sphere. They hide and suffer from many issues, but they will not share them with others. They grew up with this practice." (KII, programme officer, age 54; Urban Gaibandha)

Attitudes of adolescent and youth towards CSE

Adolescents and youth generally hold negative attitudes towards CSE, with both males and females perceiving it as a secretive and shameful topic. Numerous taboos surrounding sexuality further contribute to their discomfort, making open discussions nearly impossible. As a result, students feel uneasy when teachers attempt to introduce these topics in the classroom, even if those students have previously participated in CSE or SRHR training or workshops.



This reluctance is also evident among youth volunteers involved in projects like RHRN. They report facing restrictions from school authorities and parents when attempting to conduct CSE sessions in schools or community settings. A female youth volunteer from Rangamati shared her experiences conducting educational and awareness sessions in the community, highlighting the difficulties in openly discussing these topics due to persistent social norms and discomfort.

“Parents often don’t acknowledge the importance of discussing such topics. They feel embarrassed to talk about these subjects. For instance, if we suggest discussing menstruation, they often dismiss it, questioning the need to revisit the topic. Some argue that discussing such matters might make girls more defiant or lead to unnecessary discomfort, especially in group settings.” (Female youth volunteer, age 23, Rangamati)

She (Female youth volunteer, age 23, Rangamati) also added a story of her experiences in conducting sessions in a Madrasa (Case 2)

Case 2

In Rangamati, local youth volunteers conducted educational and awareness sessions on sexual and reproductive health (SRH) in both community and school settings. One volunteer shared an experience:

“We visited a madrasa to conduct a session on sexual and reproductive health with the students. When we explained our objectives to the headmaster, he seemed hesitant. He asked, ‘What exactly do you mean by discussing this topic?’

We clarified that the session would focus on sexual and reproductive health education for both boys and girls. After listening, the headmaster reluctantly agreed, but firmly stated, ‘You can discuss the topic, but I don’t want words like sexuality, sex organs, or intercourse to be used.’ His discomfort was evident.

Despite this resistance, we emphasised the importance of addressing these subjects openly and accurately to help students navigate the challenges they



face. During the discussion, a female teacher added, ‘Okay, go ahead, but keep it superficial. Don’t go too deep into the details.’”

This interaction illustrates the cultural sensitivities and barriers encountered when introducing SRH education in conservative environments. Teachers and administrators may permit basic information but remain wary of more explicit discussions, reflecting a broader cultural reluctance to openly engage with these topics.

Another young male volunteer (age 25, MSS student) from Bhola also shared similar types of experiences in which they faced resistance from school to conduct SRHR sessions with students (Case 3).

Case 3

“This is Bhola, and people here—especially in rural areas—tend to be very conservative. We often struggle to discuss topics like sexual and reproductive health, facing resistance on multiple fronts. Students are generally hesitant to engage in these conversations, and open discussions can be quite challenging. Additionally, many teachers at these institutions do not respond favourably to our attempts at conducting educational and awareness sessions.

For instance, during one of our school campaigns, we invited a medical officer from our local union health centre to support a session on reproductive health. Initially, the head of the institution had agreed to the programme. However, after the session concluded, both he and his assistant teacher displayed clear disapproval. Despite having given prior consent, the headmaster later informed us that such programmes would no longer be permitted at their school, stating that these discussions were inappropriate for their institution.” (Male volunteer, age 25, MSS student)

Despite their discomfort, some adolescents and youth who had participated in SRHR or CSE-related training acknowledged the importance of understanding puberty and related health issues. Although they recognised the need for this knowledge, prevailing social stigma, norms, and feelings of embarrassment continued to impede open dialogue. This highlights that while there is an awareness of the value of CSE, cultural and social pressures still act as significant barriers to discussing these topics, even within educational settings.

In Dhaka, a different perspective on CSE emerged from IDIs and FGDs with respondents from gender-diverse communities. Many of these individuals had participated in SRHR-related training or workshops and understood the significance of CSE. Both male and female youth emphasised that CSE should be openly discussed and accessible to everyone, despite existing social norms discouraging such conversations.

They emphasize the need for education on gender diversity and sexual orientation, as these topics are often misunderstood in communities. They highlight the importance of differentiating and clarifying these identities, as various sexual orientations are frequently misclassified under the broad category of "third gender." Additionally, they stress the importance of teaching respectful treatment and providing mental health support for gender-diverse individuals.

One respondent from the gender-diverse community expressed a pressing need for greater awareness and education on these subjects, reflecting a more progressive attitude in Dhaka compared to other regions. These insights suggest a broader desire for inclusivity, better understanding, and a more informed approach to gender and sexual diversity within the framework of CSE.

One respondent from gender diverse community (GDC) expressed in FGD-

“Adolescents and youth should study CSE. . .if they are knowledgeable about gender diversity, they will not disrespect those who belong to other genders. . . They will understand the feelings of people who belong to the other gender.” (Youth male, age 23, Dhaka)

Respondents from the gender-diverse community emphasised that issues related to gender and sexual diversity should be incorporated into the CSE curriculum, training and awareness

programs. They believe that this inclusion would help foster positive relationships and increase acceptance of diverse communities by adolescents and youth. Raising awareness on these topics would correct misunderstandings and promote a more inclusive mindset toward gender-diverse individuals.

Among the respondents, 6 -10th grade students reported difficulties studying CSE materials at home due to a lack of privacy and a supportive environment. Many feel uncomfortable and embarrassed discussing or studying these topics in the presence of older siblings or parents. This lack of a conducive home atmosphere further discourages open dialogue and learning about important CSE subjects, making it challenging for students to engage fully with the material. During a FGD with the adolescent students, one of the students said-

“Our teachers only take a few classes on ‘wellbeing’. Even if, when they conduct a class, they do not cover the full discussion and chapter on ‘sexual and reproductive health’, they skip this chapter and give us homework to read at home. But we are not comfortable to read this subject at home” (FGD, adolescent-boy, Age-15; rural Gaibandha)

The home environment in which many students attempt to study their CSE materials often proves unsupportive, marked by tension and discomfort. Within these households, adolescents frequently feel a sense of embarrassment and apprehension whenever they open their CSE textbooks. It is not merely a matter of curiosity or academic diligence thwarted; rather, the very act of opening these books risks drawing scornful or irritated reactions from parents, guardians, or older siblings. Such family members, upon noticing the subject matter, may respond with disapproval, questioning the worthiness of “these offensive issues” being taught at school.

This pattern of negative remarks is sometimes followed by reproachful questions like, “Is this why we are sending you to school?” discouraging students from engaging with the study material. Criticism and moral judgment discourage students from exploring sexual and reproductive health education. Over time, negative responses reinforce stigma, making students hesitant to seek clarity or ask questions. This not only affects their immediate learning but also hinders their long-term understanding of these essential topics.

Attitudes of parents towards CSE

Parents hold a generally negative attitude toward Comprehensive Sexuality Education (CSE) because they associate it with sexuality and romantic relationship-related topics. They believe that exposing children to these subjects will make them “too mature for their age.” They also believe that it may lead their children to romantic involvement or risky behaviours like premarital sex and other sexual behaviours. There is a widespread fear among parents, we found in this study that CSE may encourage children to engage in experimenting in romantic relationships and sexual behaviours, potentially promoting activities like premarital sex or other behaviours considered morally or socially unacceptable.

Additionally, parents believe that teachers, seen as respected “guardians” in society, should maintain certain boundaries. Discussing topics like menstruation, wet dreams, puberty, body changes, family planning, and mental health in class could make students feel uncomfortable and undermine the respect traditionally held for teachers. Many parents feel that these discussions erode existing values, and some view CSE as conflicting with religious and cultural beliefs.

Parents argue that schools should focus on teaching ethics, morals and virtues, rather than subjects related to sexuality. In regions like Sreemangal, Bhola, Gaibandha and Khulna, most parents believe that only hygiene and puberty-related topics should be taught in schools and that boys and girls should be taught separately. This separation would help prevent potential romantic relationships from forming in co-ed settings.

“School can teach children about their physical changes but not beyond that. . . discussion session also not be appropriate where both boys and girls are present”
(Parent of an adolescent girl, age 42, Khulna)

In some communities, certain parents strongly oppose making CSE a mandatory component of co-educational schooling. They advocate for instruction to be delivered in strictly gender-segregated sessions, with male teachers teaching boys and female teachers teaching girls. This preference stems from the belief that allowing boys and girls to learn CSE together would inevitably encourage romantic or sexual attractions and relationships among students.

Such perceptions pose substantial challenges to the implementation of CSE. The very notion of mixed-gender classes become entangled with fears of moral decay or early romantic entanglements. When incidents of romantic involvement or premarital sexual activity arise among students, these parents are quick to attribute such behaviour to the influence of co-education or the introduction of CSE into the curriculum. This response not only stigmatises the subject matter but also impedes the development of a well-rounded and informed approach to sexual and reproductive health education.

A secondary school teacher shared a story about parental complaints against teachers due to their children's premarital sexual engagement premarital sex in Khulna, as follows-

“Last week, an incident happened- a boy who studied in 8th grade and a girl from 6th grade was caught in a house near the school... they were engaging in a sexual relationship, and their parents were angry against the teachers as we did not give them proper moral education unaware of it” (High School teacher, age 50, Khulna)

Another case story (Case 4) can be explained from the IDI of a 45 years old woman who is a mother of 3 young boys and one adolescent daughter for understanding the parental attitude towards CSE.

Case 4

A 45-year-old woman, who had separated from her husband at the age of 33 and returned to her parent's house with her four children in Sreemangal. To support her family, she worked in a tea garden and sometimes as a day labourer to make a living. Having been deprived of education herself, she understood its value and made every effort to ensure her children received an education, believing it could provide them with a better future. Understanding the importance of education, she tried hard to provide support for continuing education for her children because she had been deprived of it and realised that with education, she could have had a better life. She was also active in her community, volunteering and attending courtyard seminars and community meetings organised by various NGOs.

One day, she learned that a workshop on sexual health issues would be organised for parents and adolescents in this community. She took her 14-year-old daughter to participate and learn about these important issues. After the workshop, her daughter learned a lot about

menstruation, hygiene, wet dreams, safe sexual relations, the disadvantages of early marriage, pregnancy, family planning, and more, as she reported. Initially, the mother was happy for her daughter as she thought, now her daughter knew many new issues.

However, when she noticed that her daughter now openly and comfortably discussed matters like menstruation and puberty-related issues, she couldn't accept it. She felt uncomfortable hearing these words from her daughter. According to her, her daughter should not discuss such matters openly because it is shameful and not an issue meant for open discussion. She worried that others might think her daughter was a "bad girl" and assume she was having a romantic relationship with someone. Another reason for her discomfort was that, although she believed these issues should be learned about, she also perceived that these were secret matters not to be openly discussed. So, she told her daughter not to talk about those topics again.

Attitudes of teachers towards CSE

In all the studied regions, most teachers responsible for delivering CSE in schools did not personally hold negative views toward the subject. They generally understood the importance of educating students on sexual and reproductive health topics, recognizing that such knowledge is critical for informed decision-making and overall well-being. At the same time, however, these educators were acutely aware of the broader social and religious landscapes in which they operated. They emphasised the need to carefully select which topics to introduce, to determine the appropriate age for such lessons, and to gauge how deeply they should delve into sensitive subject matter—all with the goal of respecting local beliefs, attitudes, and cultural norms.

Despite this acknowledgment of CSE's value, interviews revealed that teachers frequently chose to bypass these chapters in their curriculum. Their reluctance stemmed not from personal disapproval but from the misunderstandings and negative reactions they encountered. Many teachers faced resistance both within the classroom—where students might respond with discomfort or unease—and outside of it, where parents expressed confusion or alarm over what was being taught. Under pressure from these mixed reactions, teachers often found it easier to

skip or gloss over CSE content rather than risk conflict or further misunderstanding, thereby limiting students' access to this essential information.

Teachers interviewed through KII emphasised that, while the Ministry of Education in Bangladesh possesses the authority to roll out any form of curriculum—including CSE—such initiatives must consider the country's diverse tapestry of attitudes, beliefs, and social norms. The teachers further mentioned that many parents believe there is no pressing need for children to learn about CSE at an early age, preferring instead that young people gain this knowledge informally and “naturally” as they grow older.

Because of these prevailing views, CSE remains widely misunderstood, and parental reservations frequently overshadow its educational value. Teachers reported facing direct challenges from both parents and influential community figures, who often question the appropriateness of CSE content in the classroom. This pressure creates a restrictive environment where educators, despite acknowledging the importance of these lessons, find themselves constrained. Even those who wish to provide students with a more thorough understanding of sexual and reproductive health feel compelled to limit their engagement with CSE, fearful of the backlash that open, frank discussions might invite.

In many schools, CSE receives minimal attention due to the limited number of classes allotted to these topics. Compounding this issue, the CSE curriculum is neither evaluated nor included in formal examinations. With no tests or assessments attached to the material, neither students nor teachers feel compelled to treat it with the same seriousness as other subjects. Over time, this absence of accountability and measurable outcomes results in a lack of motivation to engage deeply with CSE content. Without any formal incentives or penalties, educators often find it easier to skip or gloss over these lessons, further reducing the likelihood that students will receive a thorough, meaningful education in sexual and reproductive health.

In Bhola district, a male teacher who also serves as a master trainer in CSE shared his personal experiences, shedding light on the complex reality of teaching these subjects. While he fully recognises the importance of equipping students with knowledge about sexual and reproductive health, he finds himself operating within a constraining environment. His struggles result from

two primary concerns: the lack of emphasis on CSE in examinations and the powerful social taboos that surround frank discussions of sexuality.

Since CSE is not integrated into formal assessments, students and teachers alike have few academic incentives to engage meaningfully with the material. This devaluation in the educational hierarchy—where tested subjects command more respect and attention—fuels an ongoing reluctance to invest time and effort in these lessons. In addition, broader societal discomfort and stigma regarding the open discussion of sexuality intensify the challenge. The teacher noted that both students and educators become hesitant in the face of these deeply ingrained cultural norms, reinforcing a cycle where CSE remains on the periphery of the curriculum. As a result, despite the teacher's understanding of CSE's critical importance, multiple layers of resistance—academic, cultural, and social—limit his ability to provide students with the comprehensive, open, and informative education they need.

Sometimes, some young males will tease a teacher, creating further embarrassment-

“When I conduct classes on sexual and reproductive health in 6th to 8th grade, students take it very seriously... but some students do not take class seriously. They ask some unexpected questions and make the environment embarrassing for me and female students as well. They will ask me, “What is sperm, Sir? How does it come out?” (Key informant, master trainer of ‘wellbeing’, Bhola Sadar)

A physical education teacher who also teaches CSE at a school in Bhola shared that he feels undervalued among his colleagues because of his role in teaching the CSE subject. This sense of being undervalued stems from the general lack of respect and recognition given to CSE topics in the school environment, which is further reinforced by societal discomfort around discussing these issues.

Despite these discomforts, we found some female teachers in Gaibandha and Rangamati urban areas who were interviewed, expressing that they discussed many other SRHR issues beyond school curriculum, particularly with their female students. However, they did not face such restrictions from the community (Case 5).



Case 5

A female physical education teacher in a high school in a suburban area of Rangamati has been teaching for the past 25 years. All the students in her school come from ethnic communities. While she teaches comprehensive sexuality education (CSE) to both boys and girls, she pays special attention to discussing future life plans with female students in grades nine and ten. She shared her approach:

"Many of these girls will get married soon, some even right after appearing for their SSC exams. I try to motivate them to avoid early marriage. Even if they do get married, I advise them not to conceive early. I explain that there are various methods available to prevent pregnancy. I believe they are mature enough to understand this information, and it will help improve their lives."

The teacher reported that she has not faced any challenges or resistance from the community regarding these discussions. She suggested two possible reasons: either the girls do not share these lessons with their families or community members, or the community may quietly accept such discussions. Her efforts highlight the importance of providing young women with the knowledge to make informed decisions about their health and futures, even in culturally sensitive settings.

In the study, we observed notable differences between schools in urban and rural areas regarding CSE. While detailed discussions on CSE topics were uncommon in both settings, CSE was slightly more discussed in urban schools compared to rural ones. Urban students and teachers appeared to be somewhat more open to discussing certain CSE topics, such as puberty, reproductive health, and hygiene. However, despite this increased openness, the number of classes allotted for CSE in both urban and rural schools was still inadequate to cover the full scope of the curriculum.

This lack of time and focus in both urban and rural schools lead to a shallow understanding of CSE among students, with important topics being skipped or not given enough attention. The insufficient class hours and the undervaluation of the subject by educators and society and societal restrictive norms to discuss CSE openly are significant barriers to the effective teaching and learning of CSE.

Attitude of faith leaders towards CSE

In this study, interviews were also conducted with a few faith leaders, including those from Islamic and Buddhist backgrounds. These leaders offered alternative perspectives on CSE, rooted in their religious values and teachings.

Islamic Religious leaders Perspectives

Madrasa teachers highlighted that students in madrasas should be educated about the physical changes that occur during adolescence, such as puberty, but emphasised that the knowledge imparted should be limited to an understanding that these changes are normal and natural. They stressed that the focus should be on guiding students to maintain personal hygiene, particularly of their sexual organs, as it is crucial for fulfilling religious obligations. This hygiene is necessary for reciting the Holy Qur'an and performing the five daily prayers (Salah), where cleanliness is a key component of Islamic practices.

These Islamic teachers expressed concerns about CSE expanding beyond these fundamental lessons, especially into areas they believe might expose young students to inappropriate or overly detailed sexual content. Their viewpoint reflects a desire to balance essential health education with adherence to religious principles as they viewed it.

One of the *Kawmi*¹ Madrasa teachers from Gaibandha shared,

“The Holy Quran contains everything and provides solutions for every problem... If someone lives their life according to the Quran, they won't need any other CSE education, and there won't be a need to discuss it openly.” (KII, Madrasa Teacher, Age 40, Gaibandha Sadar)

Additionally, the faith leaders expressed concern about disseminating extensive knowledge on CSE at an early age, especially at the high school level. They argued that providing too much information about SRH could potentially lead students to develop an interest in sexual activities, which are socially and religiously prohibited.

They maintained that while it is essential for students to understand basic concepts related to their bodies, puberty, and personal hygiene—especially in relation to religious practices—

¹ The Qawmi madrasahs are not regulated by the Bangladesh Madrasah Education Board. As private charitable organizations, Qawmi madrasahs are supported almost exclusively by donation.

delving into more detailed sexual knowledge could be counterproductive. According to these leaders, if adolescents are exposed to discussions about contraception, sexual relationships, or reproductive rights too early, it might encourage behaviours that conflict with social norms and religious teachings, such as premarital sex or other "prohibited" activities.

This stance reflects a desire to protect young people from what these leaders perceive as negative influences by limiting their exposure to information that could prompt curiosity or experimentation with behaviours that are seen as immoral or harmful in a religious context. Therefore, they advocate for a more restrained and carefully curated approach to CSE, one that focuses strictly on essential health knowledge while avoiding topics that might be perceived as encouraging forbidden practices.

Although most of the Islamic religious leaders we interviewed showed restrictions to CSE education, one madrasa teacher, who was also an Imam of a mosque, showed a positive attitude and expressed that adolescents and youth should have some knowledge of puberty and SRHR. He has participated in many GO-NGO development campaigns, training, workshops and events. He also teaches 'health education' in his Madrasa. He expressed -

"Other teachers sometimes undermine my openness and criticise my support for CSE. I believe our society is not open enough to discuss these sensitive topics. However, adolescents and young people need this knowledge. With proper information, they are far less likely to engage in harmful activities." (Madrasa teacher, age 55, Bhola)

Buddhist Religious leaders Perspectives:

Similarly, Buddhist faith leaders expressed a need for education about bodily changes during adolescence but underscored the importance of teaching in a way that aligns with moral and ethical values. While not objecting to the need for students to be aware of hygiene and reproductive health, they advocated for maintaining a focus on moral teachings, such as self-discipline and respect for others, to guide students' behaviours and decisions as they mature.

Both religious perspectives highlight the importance of tailoring CSE content to respect religious and cultural norms while still providing necessary health and hygiene education. However, the broader topics of CSE, such as sexual rights, contraception, and relationships, were seen as potentially conflicting with traditional religious teachings. This presents a

challenge in integrating CSE into religious education settings where moral and religious boundaries are emphasised.

A faith leader from Rangamati who is a Bhante² (Faith leader of Buddhist religion) shared his opinion regarding teaching adolescent CSE. He said-

“It is better to learn on your own. They can read books to learn and acquire more knowledge...not necessary to teach in class. (KII, Faith leader, Bhante, Rangamati)

During discussions with youth volunteers and key informants from Khulna, it was revealed that when they visited madrasas (Islamic religious schools) to share knowledge on CSE topics, they faced significant restrictions. Before conducting these sessions, they were required to obtain permission from the head teacher. Moreover, they were explicitly instructed not to use certain words, such as "sex," "sexuality," "penis," and "vagina."

These limitations reflect the sensitivity around SRH topics within the religious education system and highlight the careful balancing act required when addressing such subjects in madrasas. The emphasis was on avoiding any direct references that might be deemed inappropriate or offensive in a religious context. As a result, discussions about CSE in madrasas are often constrained, making it challenging for youth volunteers to communicate comprehensive and accurate information about sexual health and development.

Our findings suggest that the behaviours exhibited by adolescents and youth regarding SRH stem from a combination of factors, including a lack of knowledge, limited access to information and constructive entertainment, and exposure to adult films and media. This exposure often fuels their curiosity and leads to exploration without proper guidance. The absence of adequate CSE leaves these individuals vulnerable to numerous health risks and challenges, as they lack the essential knowledge to navigate their sexual development and make informed decisions.

Addressing these issues through the inclusion of comprehensive CSE in the curriculum is crucial. By providing accurate information about sexual health, body changes, contraception, and relationships, CSE can equip adolescents and youth with the necessary tools to make

² Bhante- A respectful title given to a Buddhist monk, nun or superior, especially in the Theravada tradition.

informed and responsible decisions regarding their health and well-being. Moreover, it can help dispel misconceptions and reduce the curiosity driven by harmful or inappropriate media influences, ultimately promoting healthier behaviours and attitudes towards SRH among young people.

This underscores the tension between promoting essential SRH knowledge and adhering to socio-cultural and religious norms, which can affect the effectiveness of CSE programmes in conservative settings.

4.1.3 Knowledge and attitudes regarding SRHR

Similar to the findings on CSE, in five of the study areas (except Dhaka), many respondents from FGDs and IDIs—including adolescents, youth, parents, and community members—demonstrated a lack of awareness and understanding about SRHR. Most of them associated the term "sexual" with sexual activity or behaviour, and "reproduction" with childbirth.

This limited understanding often leads to misconceptions, with respondents hesitant to engage in discussions on these topics due to the stigma and taboo associated with sexuality and reproductive health. These findings reflect the pressing need for awareness and education on SRHR in these communities, as the lack of knowledge can hinder access to essential services and create barriers to promoting gender equality, sexual health, and reproductive rights.

The confusion around SRHR highlights the importance of developing educational and outreach programmes that clearly explain the scope of SRHR, addressing the misconceptions, and ensuring that people understand its broader focus on health, rights, and well-being beyond just sexual activity and reproduction.

Knowledge and attitudes regarding SRHR among adolescent and youth

Knowledge about SRHR

In our study areas Sreemangal, Gaibandha, Bhola, Khulna and Rangamati, discussions from FGDs and IDIs with both male and female respondents revealed that most respondents were unfamiliar with the term SRHR. They had no understanding that knowledge about sexual health and access to SRHR services are basic human rights to which every person is entitled. Even among the youth, awareness of SRH issues were scarce and incomplete. Those who had some

knowledge often gained it through specific engagements, such as training programmes or workshops.

For example, a male youth leader from Khulna, who had been working for three years as a volunteer with the RHRN2 programme, described the limited knowledge of adolescents and youth from his experience working in the field. He shared-

"After joining the RHRN programme as a volunteer, I received training from the organisation, and I learned about SRH issues... for example, menstruation, wet dreaming, masturbation, safe sex, contraception (use of pills and condoms), HIV, and other sexual diseases and infections." (IDI, youth-male, age-20; rural Khulna)

This highlights that while participation in programmes like RHRN helps increase awareness among youth, there is still a significant knowledge gap in the wider community, especially in rural areas, regarding SRHR. Many respondents had little to no awareness that SRHR are basic human rights that every person is entitled to, including the right to access safe health services, information, and education on SRH issues. This demonstrates a significant gap in both biological knowledge and rights-based understanding of SRHR, which needs to be addressed through comprehensive education and awareness programmes, as well as the need for more accessible, widespread education on SRHR topics.

Although some adolescents and youth have limited information about SRHR, many still hold misconceptions. For instance, researchers discovered that both male and female adolescents and youth often perceive natural biological processes like "*shopno dosh*" (wet dreams) and menstruation as illnesses, rather than normal aspects of human development. This misunderstanding reflects a broader lack of knowledge on SRH topics, leading to anxiety and stress among young people.

However, we found that respondents from gender-diverse groups in this study exhibited better knowledge of SRH and rights issues. All of these respondents had received training on SRHR-related issues, which contributed to their higher level of awareness. Additionally, all respondents from gender-diverse groups had completed more than 12 years of education, which may have further contributed to their better understanding of SRHR topics.

This contrast highlights the importance of education and training in improving knowledge of sexual and reproductive health and rights, particularly among marginalised or gender-diverse

communities. These groups' enhanced understanding suggests that targeted educational programmes can significantly impact awareness and knowledge levels across diverse populations.

One KII from this group stated that-

"We provide regular training to the members of the organisation . . . they are also eager to know many things . . . They have peer group discussions, they regularly shared their knowledge and learning in this peer groups" (KII, Programme person, Dhaka)

Attitudes towards SRHR

From the IDIs and FGDs with adolescent girls and youth, we identified a notable gap in knowledge about SRH in all study sites (except Dhaka, as all of our respondents from Dhaka were more than 12 class of education) among adolescents and youth who are relatively less educated (less than 12 class of education). Many parents, family members, and friends also lack sufficient understanding of SRH topics, leading to a negative attitude toward openly discussing these issues. Key informants in this study, including teachers, health workers, and programme personnel, echoed this sentiment.

Moreover, even when mothers, family members, or close relatives possess some knowledge about SRH, they often refrain from sharing it in detail due to feelings of embarrassment, traditional values, and prevailing gender norms. For instance, an unmarried girl currently working with an NGO in Rangamati expressed her perspective on how adolescents typically learn about SRH issues-

"I learned about these things from friends at school and through social media. I wanted to ask my mother, but I felt she would be uncomfortable discussing it. It's not something we talk about openly in our family." (Youth, girls, age 19, Bhola)

This reflects the broader trend where adolescents often turn to peers or external sources for information due to a lack of supportive discussions within their families. The reluctance to engage in conversations about SRH can perpetuate misinformation and limit young people's ability to make informed decisions regarding their health and well-being.

Another unmarried girl working with an NGO in Rangamati shared her perspective on how adolescents in her locality typically learn about SRH. In most cases, mothers only share

knowledge and information when a girl reaches puberty and experiences menarche (her first period). She recounted her own experience-

"When I was in primary school, I first heard about 'menstruation' from my elder sister. It was funny to me, and I didn't believe that it happens to everyone. I only believed it after experiencing my first menstruation in school. My mother didn't talk about it before; she only discussed it after the first time I experienced it." (IDI, youth-female, age-28, Urban Rangamati)

This narrative reveals that discussions about SRH often happen after an event like menarche, rather than proactively, reflecting restrictive attitudes toward sharing and discussing SRH information within families.

In addition to the reluctance to openly discuss SRH, nearly all respondents from IDIs and FGDs, along with community members and parents, believed that individuals should obey normative values and adhere to social practices rooted in tradition. When the conversation shifted to individual rights—the right to choose or make decisions about one's SRH—married female respondents mentioned that they rarely have the opportunity to express or practise these rights.

Furthermore, the study identified patriarchal attitudes prevalent in the community, with married women reporting that they often could not refuse their husbands' sexual demands, even during their menstrual periods. A few married women from Sreemangal, Gaibandha, and Bhola shared that their husbands expected sexual intercourse despite their physical discomfort. One extreme case (Case 6) from Gaibandha involved a woman whose husband forced her into sex on the same night of her wedding, although the girl was not willing to. Her sexual organs were severely injured due to this forced sex.



Case 6

A few months earlier, an incident happened in our nearest locality of urban Gaibandha. An adolescent girl was married off at an early age; aged 13–14 and her husband was 18 or 19 years old. On the day of her wedding, she had her first sexual encounter with her husband but he failed to have successful intercourse. He was unaware of the process so he brutally cut her vaginal openings with a blade to enlarge it so that he can easily have intercourse. However, the girl was bleeding severely from her vagina, and then her husband's family member admitted her to a hospital in Gaibandha Sadar. But she had to be transferred to Rangpur Medical College. She was admitted for several days to recover and later she stayed at her parent's home for some days. After she recovered, her family forced her to move to her husband's house, though she was traumatised. Her family then forcefully took her to her in-laws' place because the family believed that the ultimate destination for a girl was to be in her husband's place. She should do as her husband directs since, as her grandmother once said, "Women are vessels for husbands to enjoy. (Married girl, age 24, FGD, Gaibandha)

The incident is a tragic reminder of the realities many girls face due to early marriage and a lack of understanding about consent and bodily autonomy. This situation highlights several urgent issues, including the necessity for education around sexual health, the protection of minors from child marriage, and the importance of addressing deeply ingrained cultural beliefs about gender roles. It also reveals how traditional beliefs can perpetuate cycles of trauma and abuse.

Many married women reported that their husbands viewed the wife's primary role as fulfilling their sexual desires, often lacking empathy in such situations. This attitude reflects deeply rooted patriarchal norms that limit women's autonomy over their bodies and prioritize social norms to obey husband's demands over their well-being. In some cases, husbands perceived their wives as obligated to engage in sexual intercourse regardless of their physical or emotional state, highlighting the pervasive influence of these norms.

In this context, the men's lack of knowledge and sensitivity, as well as that of other family members, regarding a young girl's physical readiness for intimate relationships—and the complete disregard for her consent—is profoundly concerning. This situation highlights a

broader issue: inadequate sexual education and insufficient awareness around sexual activity, sexual health, consent, and safety. Many men in these communities fail to show empathy toward women's physical discomfort or limitations, particularly in intimate situations, due largely to entrenched gender norms, cultural beliefs, and societal expectations.

In the six study areas, it was found that women often view themselves as subordinate to men and see their primary role as satisfying their husbands' needs under any circumstances, including situations where they may feel unprepared or unwell. This belief is deeply rooted in traditional patriarchal values that dictate a woman's role as being primarily submissive to her husband's desires.

However, despite the overall resistance to discussing within communities, there are some exceptions. Health workers, including doctors, community health workers, and medical students, are generally more trusted sources of information on SRHR. Across all the study areas, respondents noted that when health professionals—such as doctors or community health workers—talk about SRH issues, including STDs and infections, the community members are more open and willing to listen.

The professional status of health workers and their familiarity and trust built with community members play a significant role in overcoming barriers. For example, a young married female respondent explained that her community is more receptive to SRHR information shared by doctors or health workers. However, this openness tends to be limited to married adults, as the community prefers to exclude adolescent boys and girls from such discussions. They feel that SRHR topics are only appropriate for married individuals and unmarried adolescents are often seen as too young to be included in these conversations.

This dynamic shows the potential for health workers to play a key role in spreading accurate information about SRHR, but also highlights the ongoing challenge of addressing taboos around these topics, particularly when it comes to unmarried adolescents.

Gaps in understanding about gender diversity

In addition to these challenges, respondents from gender-diverse communities pointed out that there are many misconceptions surrounding gender diversity and sexual orientation. Even though the government recognises hijra as a third gender, there is still widespread misunderstanding among the government, civil society, and the general public about the

differences between hijra transgender individuals, and other gender-diverse groups. These misconceptions create further complexity when gender-diverse communities try to stop discrimination, and demand their rights or seek acceptance.

For example, respondents mentioned that the lack of awareness and education about gender diversity leads to stigmatisation and marginalisation of these communities, making it difficult for them to access support and or any resources. In classrooms and community settings, there is often a lack of open discussion about gender and sexual diversity, further perpetuating myths and stigma.

The combined reluctance of teachers and communities to discuss SRH and the misunderstandings surrounding gender diversity highlight a need for more inclusive education that addresses both SRHR and gender diversity in a way that is culturally sensitive and inclusive, to ensure good health and well-being of young people.

The findings demonstrate that traditional, conservative attitudes and misconceptions continue to hinder the implementation of CSE. These cultural and social barriers prevent adolescents and youth from accessing essential knowledge about their sexual and reproductive health, creating a need for more targeted approaches to addressing community resistance and enhancing SRHR education. Addressing these barriers will require a multi-faceted approach that includes educating teachers, community leaders, religious leaders and other key stakeholders.



Key Findings: CSE -

The study reveals widespread negative perceptions of Comprehensive Sexuality Education (CSE) across various regions, driven largely by traditional and cultural beliefs, with the exception of Dhaka, where respondents from gender-diverse communities (GDC) had a more informed understanding of CSE. Here are key findings:

1. Negative Perceptions of CSE:

- In all study areas, except Dhaka, CSE is viewed negatively due to the association of the term "sexuality" with sexual relations, which is considered taboo.
- Both FGD and IDI respondents predominantly believed that CSE focuses on puberty and sexual relations, which reinforced community concerns.

2. Parental and Community Resistance

- Many parents and community members believe CSE encourages inappropriate discussions about sex, associating it with free mixing among adolescents. They oppose its inclusion in schools, fearing it will lead to early romantic or sexual relationships.
- The word "sexuality" in the CSE curriculum fuels misconceptions that the subject promotes sexual activity, leading parents to avoid conversations on the topic with their children.

3. Teacher Discomfort

- Teachers, particularly in Madrasa education systems, were uncomfortable discussing SRH topics, especially in co-ed settings. Words like "jounango" (genitals), "sex", and "ston" (breast) made them uneasy, leading to incomplete or superficial lessons.
- Physical Education teachers, often responsible for teaching CSE topics, felt unappreciated compared to colleagues due to the stigma attached to CSE subjects.



4. Classroom Dynamics

- When puberty and menstruation were discussed, boys often reacted with laughter, while girls felt embarrassed, underscoring the lack of openness around these topics.
- The cultural taboo surrounding SRHR issues made it challenging for students to gain comprehensive knowledge, leaving many adolescents under-informed about essential reproductive health matters.

5. Adolescent Knowledge Gaps:

- Unmarried adolescent girls and young women have limited understanding of SRHR, family planning, and contraception.
- Boys generally possess even less knowledge, especially on topics like menstruation and puberty, and rely on unreliable sources like the internet or pornography for information.
- Misconceptions about SRHR, such as thinking wet dreams are a sexual illness or concerns over genital size, persist among adolescents, who often seek help from traditional healers.

6. Gender Disparities in SRHR Understanding:

- Married adolescent girls and female youth have better SRHR knowledge, especially regarding contraception and family planning, compared to their male counterparts. However, both genders lack accurate SRHR information overall.

7. Challenges at Home:

- Adolescents feel uncomfortable studying CSE topics at home in the presence of parents or older siblings. Girls rely primarily on female friends or peers for information, while boys often turn to the internet for answers, which can lead to misinformation.

8. Cultural and Patriarchal Norms:

- Patriarchal attitudes and social norms perpetuate gender disparities in SRHR knowledge, contributing to harmful practices like forced sexual intercourse during



menstruation.

- Mothers rarely discuss topics like menstruation or safe sexual practices with their daughters, and conversations around sexuality are considered inappropriate or shameful from a young age.

9. Healthcare Workers as Trusted Sources:

- Despite the societal stigma surrounding SRHR topics, health workers are more accepted as sources of information on these issues in the community.
- The findings demonstrate that traditional, conservative attitudes and misconceptions continue to hinder the implementation of CSE. These cultural and social barriers prevent adolescents and youth from accessing essential knowledge about their sexual and reproductive health, creating a need for more targeted approaches to addressing community resistance and enhancing SRHR education.

4.2 Family Planning

This section describes knowledge and perception about FP among adolescent and youth, parents and community peoples of the study areas. We also identify beliefs, attitudes and norms prevailing in the society and its influences in FP practices.

4.2.1 Knowledge and perception about family planning among adolescent and youth

The study revealed that respondents from different sites had a diverse understanding of family planning (FP), FP methods, and services, shaped by factors such as area of residence, marital status, education, and gender.

A significant number of unmarried and married adolescents and youth, both male and female, perceived family planning primarily as a means of ensuring the well-being of families and living together, which they saw as a plan for maintaining family harmony and care.

When asked about their understanding of “*jonmo niyontron*” (population control in Bangla), they interpreted it as the control of pregnancies and childbirth or the choice and decision of having a child. Once this connection was made, respondents could then correlate family planning with population control, seeing it as a way to manage childbirth and population size.

This finding highlights a knowledge gap where many young people and adolescents tend to focus on family well-being rather than the technical aspects of contraception and reproductive health with deeper understanding emerging only when explicitly linked to population control or childbirth management. In addition, the term family planning which is used widely, rather than contraceptives reinforces the notion that its use is related to family size management rather than knowledge and use of contraceptive methods.

The study highlighted those married females possessed a greater understanding of family planning (FP) compared to unmarried adolescents and youth, regardless of gender. In general, male respondents displayed less knowledge about FP compared to their female counterparts. Notably, adolescent males exhibited particularly poor understanding of family planning concepts. This could be related to the fact that programs on family planning in the country have primarily been directed towards women and not men.

Some females expressed the belief that males were more knowledgeable about reproduction and sexuality, suggesting that they did not need further information. However, findings

contradicted this belief, revealing that males had limited information about puberty, family planning and other SRHR topics compared to females.

Unmarried youth and adolescents, as well as married males and females, predominantly viewed family planning as a concern primarily for married couples, focusing mainly on women and pregnant women. This perception is linked to the fact that women usually manage family planning methods, resulting in limited access to information for men. Consequently, men often possess a poor understanding of FP methods and their significance.

Moreover, the study found that most adolescents and youth, including married women, regarded family planning as primarily a female responsibility. However, youth who completed at least 12th grade or had participated in FP-related training or workshops tended to have a better grasp of family planning methods, uses and gender responsibilities. . They recognized FP as not only a matter of determining family size and birth intervals but also as crucial for maternal and neonatal health. Furthermore, they acknowledged the importance of shared responsibility in family planning within relationships, emphasising that both partners should be involved in discussions and decisions regarding reproductive health.

The study found that urban females were generally more familiar with various FP methods compared to their rural counterparts. Commonly mentioned methods included pills, implants, condoms, injections and intrauterine devices (IUDs). Among respondents from gender-diverse communities, most had completed more than 12th grade and had knowledge of contraceptive methods. However, many reported that they did not engage in sexual relations, and thus lacked practical experience with using contraception. One male respondent noted that he had sexual relations once but he did not use any contraception. Despite their understanding of FP methods, they expressed a keen interest in learning more about safe sex practices.

The primary sources of information about FP for the youth and adolescents included peer groups, mobile phones, and the internet. Youth with access to mobile phones and the internet preferred to search for information online rather than asking or sharing with others. They commonly utilised platforms like Google and YouTube. Additionally, married women often received information from other female relatives, female community members and health workers who provided routine counselling on FP and health concerns.

Some female respondents shared that they received limited advice from their mothers or elder sisters regarding menstrual health management after their first menstruation, but not about FP. The findings indicated that while mothers may impart some information to their daughters, sons rarely receive education about SRH. A widowed woman from Gaibandha expressed her reluctance to discuss FP with her son, sharing it was inappropriate for a mother to address such topics with her son. She stated-

"Fathers don't speak about these, so we often talk but indirectly, warning them not to make any wrong decisions. Now they are adults; they know more than me.... Mothers do not speak with their sons about these issues as it is shameful." (KII, Mother, Age 48, Gaibandha)

Some youth and adolescents had received training on SRHR and participated in sessions organised by various volunteer organisations associated with RHRN2. For instance, a teacher from Rangamati mentioned discussing topics like early marriage, pregnancy, and contraception with her female students. Another female teacher from Gaibandha emphasised the importance of waiting until the age of 22 to have children, advising her students on birth control options and how to discuss them with their husbands-

"Girls, you are not 22 yet, and you should not have children early. You can take birth control pills or consult with health workers about which method you want to use and which will be appropriate for your body and convince your husbands too." (KII, Female Teacher, Age 48, Gaibandha)

Gender-diverse respondents indicated that they had learned about FP methods from training, the internet, and peers, but they seldom discussed these issues among themselves. They also did not disclose their sexual identity or practices during the research. One female respondent from the gender-diverse community mentioned-

"I did not get any information from my family, even my peers... When I saw a TV advertisement on contraception, I searched on Google and found that there are many contraceptives that prevent pregnancy and sexually transmitted diseases, but I am not interested more as I do not need it." (Female, Age 22, GDC, Dhaka)

4.2.2 Beliefs, attitudes and social norms towards FP and its influence on FP use and practices

According to focus group discussions (FGDs), in-depth interviews (IDIs) with youth, and key informant interviews (KIIs), while contraception use is on the rise, there are significant restrictive attitudes surrounding open discussions about family planning (FP) issues. This cultural climate, along with certain beliefs and norms associated with FP practices, poses challenges to the sustained use of contraceptive methods.

In all six study regions, it was found that open discussion on FP issues are strictly prohibited for both girls and boys, regardless of their age or marital status. Engaging in conversations about FP methods often results in individuals being labelled as “*kharap chele/meye*” (bad boy/girl) or “*beshi peke geche*” (too much involved in sexual matters). Such labels imply that they are either sexually active, eager to be active, or simply thinking about sex. The fear of being blamed or labelled significantly restricts open dialogues about family planning.

"Village people (in rural areas) think that how can an unmarried girl talk about issues like family planning; she might have done something fishy (sexual relations) or have an immoral relation with boys." (FGD, Youth Female, 20-30, Gaibandha)

Consequently, even if respondents possess some information about FP, they refrain from sharing it with their peers. Another female youth from Gaibandha noted-

"It should not be discussed in front of both girls and boys. It will have a negative effect; they will make fun of it, and it will be very awkward." (FGD, Youth Female, Age 19-30, Gaibandha)

In all areas, KIIs with youth leaders and volunteers from the RHRN2 initiative—who had received training on sexual and reproductive health and rights (SRHR) and act as volunteers—revealed that they often choose to avoid discussing FP-related issues during peer discussion sessions. They proposed to utilise the audio-visual materials for disseminating FP information, as these mediums allow for a more comfortable exchange on sensitive topics.

Gender-diverse respondents expressed similar sentiments, indicating that while it may not be a topic for open discussion, those in need should still have access to information. RHRN2 youth volunteers emphasised the importance of equipping youth with knowledge before they engage in sexual activities-



“Youth should know about contraception information before having sex. . . if they do not know, there will be risks. . . but it is tough to get access to information for adolescents and youth. . . the internet may be a good option.” (Female, Age 22, GDC, Dhaka)

In educational institutions, many teachers, even those involved in teaching CSE, express hesitancy to discuss FP topics. This hesitation stems from concerns about inadvertently encouraging sexual activity among students and the potential backlash from parents. However, some educators acknowledge the necessity of providing basic FP information, especially to students in grades 9-10. For instance, a female high school teacher in Rangamati stated-

“I also give them information about family planning, very basic information . . . they will be aware of it. . . they may use family planning methods after marriage.” (Female Secondary School Teacher, Rangamati)

Conversely, there are teachers who avoid discussing FP altogether, viewing it as a subject solely for married individuals. A male teacher from Khulna expressed the importance of separating discussions for married and unmarried students to prevent any encouragement of sexual activity.

“If any of our students get married, we take special care and ensure that she/he doesn't talk or share anything with others about his/her married life, husband-wife sexual relations, because there's a possibility that it could encourage others to engage in sex.” (KII, Teacher Male, Age 38, Khulna)

The study also revealed that attitudes towards family planning are significantly shaped by religious beliefs across different religious communities, including Muslims, Buddhists, and Hindus. Many respondents believe that pregnancy is solely determined by God's will, considering children as gifts from God that should not be deliberately prevented. Both male and female respondents across all religious groups expressed the view that a woman can only become pregnant if God wills it, regardless of the use of contraception. This belief underscores the notion of divine intervention over human agency in family planning decisions.

Additionally, religious leaders play a pivotal role in influencing these beliefs through religious sermons. In regions like Gaibandha and Bhola, some Muslim youth reported that their religion opposes modern contraceptive methods. However, there was a divergence in opinions among

Muslim respondents in Khulna, who were more open to using short-term and natural contraceptive methods. As one father of a youth from Khulna remarked-

“Allah will give us children, but we should care for them. . .one should not give birth to so many children. . one needs to control.” (KII, Father of Youth, Khulna)

An Islamic faith leader (38) from Gaibandha explained that the Quran endorses family planning by referencing the practice of 'Azol', which refers to the withdrawal method during intercourse. He suggested using 'Azol' (abstaining from intercourse during ovulation periods) and using contraception to prevent sperm and egg from mixing. He emphasised the belief that-

“Allah decides everything; childbirth, their care-food-lives. Those clans which will reproduce more will be able to go to the ‘Jannah’ (Heaven).” (KII, Faith Leader, Age 38, Gaibandha)

Similarly, a socially influential male, aged 65, in Gaibandha stressed that Allah is the ultimate decision-maker in matters of life and birth. He articulated the belief that children are a manifestation of God's will, stating that-

“One (Allah) who gives life, gives food.” (KII, Influential Community Member, Male, Age 65, Gaibandha)

From the Buddhist community, a Bhante (60) in Rangamati shared that there are no specific guidelines in Buddhism that support birth control. He stated-

“There is no fixed rule for birth control in the Buddhist religion.” (KII, Buddhist Faith Leader, Age 60, Rangamati)

The Bhante values having numerous children, with the hope that at least one will grow up to be virtuous and provide support for parents in their old age. He implied that sexual relations are primarily for procreation, questioning why a woman would engage in such relations if she did not desire children. He associated infertility with misdeeds from past lives, adhering to a Karmic perspective, and considered abortion a sin due to Buddhist principles regarding the sanctity of life. The monk also suggested a specific conception method involving the use of a calendar to avoid certain days, like the 8th, full moon, and new moon.

In contrast, in the Sreemangal tea garden area, where Hinduism is prevalent, there are fewer religious or social barriers to using contraception. Many residents have faced significant



economic hardships, prompting a proactive approach to family planning to manage household size and improve quality of life. In this region, early marriage is uncommon, as the community struggles to find suitable matches within their clans due to small populations. As a result, those who marry after the age of 20 do not often use contraception; they prefer to conceive as soon as possible.

In Gaibandha, conception is largely viewed as Allah's will, with strong community beliefs in divine intervention influencing family planning decisions. Conversely, in areas like Sreemangal and Rangamati, where indigenous groups predominantly reside, norms surrounding family planning are more relaxed due to less stringent rules regarding childbirth.

Across all six study sites, married couples often feel pressured to have a baby within the first two years of marriage to demonstrate fertility. This belief is rooted in the notion that having children enhances a husband's sense of responsibility and decreases the likelihood of divorce. Parents and close relatives contribute to the pressure on couples to have children soon after marriage, believing that a baby will strengthen the couple's bond. One married youth male from Khulna noted-

“My mother always says to have children as she believes that women will be tied to the family if they get pregnant. This means if she has a child, she will not leave me; otherwise, she might.” (FGD, Married Youth Male, Age 25, Khulna)

Even if married girls or couples plan or use contraceptives, they are often pressured by their husbands (when married girls make her own decisions) or in-laws and parents to stop using contraception. A mother from Sreemangal shared-

“What kind of daughter-in-law is she? What is the use of her if she cannot give birth to a child - it's been a year” (KII, Mother, age 45, Sreemangal)

Furthermore, the analysis reveals that males, particularly husbands, exert control over the decision-making process regarding contraception. Husbands and in-laws dominate the choices and decisions of married girls in this regard. Influential members of a family such as in-laws, particularly mother, mother-in-law and sisters, significantly impact married women's decisions regarding contraceptive use. Mothers often encourage their sons to urge their wives to become pregnant, emphasising the importance of maintaining the family. A married woman from Khulna shared that she had taken pills secretly in the early period of her marriage. When in-

laws knew it, they were forced not to use contraception and then she stopped, now she is a mother.

“I had consumed pills in secret for two months but when my mother and mother-in-law discovered they scolded me for taking them saying I might not be able to have kids. I stopped immediately then I had a child.” (FGD, Youth Female, 19-30, Khulna)

The above case of the woman from Khulna taking pills secretly to prevent pregnancy reveals the stigma surrounding contraception. The secrecy she maintained suggests a lack of open dialogue and the pressure from family members to conform to traditional roles. Once her use of contraception was discovered, the pressure to stop reflects the fear of defying family expectations and social norms.

Women in such situations face immense psychological and physical risks due to the lack of control over reproductive health. Forced pregnancies, especially when a woman is not ready or does not desire them, can lead to health complications, emotional distress, and economic instability. The lack of reproductive autonomy reinforces the gendered power structures in the family and society, making it difficult for women to assert their rights.

The emphasis on procreation, especially from mothers-in-law, demonstrates how deeply ingrained cultural values prioritise childbearing over women's health, well-being, and personal choice. The importance placed on having children—especially male children—reflects societal norms that link a woman's value and role to her ability to bear children.

When couples use family planning or fail to conceive within the first 2-3 years of marriage, family and community members often speculate about infertility, leading to hurtful taunts like 'bandhya' or 'baja'. They blamed contraception use might be a reason for this infertility (Case 7 and 8). It may result in divorce or husbands may remarry. These understandings and attitudes also discourage using FP methods. A 30-year-old married woman from Bhola shared some common beliefs in the community-

“You are married for three years; you still do not have any children. Oh! God why did you not have children yet? You cannot be a mother anymore, your husband will marry another woman” (IDI, Youth Female Leader, Age 22, Bhola)



Case 7

Athina Dewan (Pseudonym) had been married for nearly three years. She is now 27 and lives in Rangamati. She had experienced an ectopic pregnancy about which she had no idea and she had to undergo surgery. During that time of surgery, surgeons had to cut her right fallopian tube in the operation theatre as there were no other options. She was prescribed bed rest for 6 months. People, specifically her in-laws started to spread rumours and badmouths about her that she might not be able to conceive a baby anymore. People started blaming her that this happened because “she consumed too many contraceptive pills”. Her mother-in-law was saying that she might have been attacked by the black magic or was under the influence of an “amulet”. So, her husband kept her in her own mother's house so that she could stay happy and at mental peace. As she was going through a trauma. Furthermore, continuous bullying, bad words from in-laws and community were common against her due to her inability to conceive. . . One day she committed suicide. (Married female, age 27, Rangamati)

In the following case (Case 8), a married woman (27) from Gaibandha, who was struggling with infertility.

Case 8

Karima Begum(pseudonym), age 27, was unaware that an irregular cycle can affect pregnancy. She suffered from an irregular menstruation cycle from the very early days of adolescence but she could not share the issue with her family out of shyness. She did not get treated or share this with her mother. Once she had been to the doctor's chamber for consultation but, due to shame and shyness, she could not continue the treatment. Once she got pregnant after 5 years of her marriage but unfortunately, she had a miscarriage. She had suffered immense social shaming and pressure from both families to give birth to a child. This had impacted her mental health condition severely. She always feels insecure about her husband remarrying another woman and has very low self-confidence. Her father-in-



law is very supportive towards her, he always tries to keep her happy. He intentionally involves her with different activities in a volunteer network, so that she can distract her mind. “People say Allah has given me punishment for my sins”. (Youth, Female, age27, Gaibandha)

This narrative highlights the diverse contraceptive practices and attitudes across six regions, influenced by local customs, education, and gender norms and expectations. The most commonly used methods—pills, implants, injections, IUDs, and condoms—vary in popularity, with the contraceptive pill being most prevalent, especially in areas like Khulna where health workers have strong connections with couples. In contrast, Bhola has seen a shift towards visiting health complexes for family planning services rather than receiving home visits.

Contraceptive use is significantly influenced by gender dynamics, particularly in many communities where traditional beliefs and societal norms play a strong role. Men often resist using methods like condoms, citing reasons such as discomfort, reduced pleasure, and concerns over their masculinity. Many perceive condom use as a challenge to their authority or a sign of distrust in their partner. Additionally, cultural expectations and misinformation contribute to reluctance, making it difficult to promote shared responsibility in contraception. As a result, women often bear the greater burden of family planning, sometimes without adequate support or autonomy in decision-making, as stated by a respondent in Khulna.

Some regions, such as Rangamati, show a preference for natural methods like withdrawal or calendar-based planning due to concerns about hormonal contraceptives. The use of condoms is sparing, though some males report that it prolongs intercourse.

Marriage age and childbirth expectations also influence family planning. In areas like Sreemangal and Rangamati, women tend to marry later (after age of 25), and there is a cultural push for couples to have their first child soon after marriage (Case 9), often without contraception, driven by beliefs about declining fertility with age. Additionally, the gap between children varies, with many couples in Khulna, Rangamati, and Sreemangal preferring a 4–5-year interval, while some rely on natural methods or MR kits to manage pregnancy spacing.



Case 9

Reshma, a 27-year-old married woman, is currently pursuing her master's degree in Bhola. She got married four years ago when she was in the second year of her undergraduate studies. Reshma and her husband mutually decided to delay having children until she completes her education. To achieve this, they have been using family planning methods, specifically condoms.

Despite their shared decision, Reshma frequently faces intrusive questions and assumptions from others. Her in-laws, particularly the neighboring aunts, often question why she hasn't yet conceived, speculating that she might have health issues. Similarly, her friends and parents urge her to have a child. However, Reshma remains resolute in her decision to prioritize her education before starting a family.

She frequently encounters taunts from neighbors but chooses to disregard them. Living in town with her husband allows her to avoid some of the more persistent criticisms and unsolicited opinions from others in her community.

In Sreemangal, respondents noted that girls often drop out of school at the secondary level. At that age, they typically do not work outside the home or even in tea gardens. Moreover, girls in tea garden areas tend to marry later due to the difficulty of finding suitable grooms within their caste, especially among the 'Ethnic Sanatan' community. Consequently, they remain at home for several years until marriage. During the day, other family members are away at work, leaving the home empty and creating opportunities for sexual encounters.

In Gaibandha, unmarried boys and girls visit char areas secretly and engage in sexual relationships. In Rangamati, many unmarried couples who plan to marry later live together in urban areas, renting houses. Although they live much like married couples, their arrangement is not widely accepted. In Bhola, respondents also reported that unmarried boys and girls rent hotel rooms on an hourly basis for sexual activities.

Respondents perceived that contraceptive use is common in these contexts to prevent frequent unintended pregnancies. Oral contraceptive pills, condoms, and emergency contraceptive pills are commonly mentioned methods used by these couples.

However, a lack of awareness about family planning among unmarried youth leads to unintended pregnancies (Case 10). This reflects a need for better SRH education and access to contraceptives for young, unmarried individuals.

Case 10

A school-going girl from Bhola got pregnant due to a sexual relationship with another boy from her community who used to come to her residence. When she was six months pregnant her mother found it out and she was married off to the boy. The boy was abandoned by his mother and both of them stayed in that girl's parental house after getting married. Both of them had to drop out of school. The boy is also overwhelmed by being a father at a young age. He has to manage household expenditures which he usually cannot maintain. Due to not having enough knowledge about premarital sexual relations, and not having information or access to contraception, they are now suffering a miserable life.

In the tea garden communities, from our FGDs and IDIs with adolescents and male and female youth, we found that sexual activity often begins at an early age, with adolescent girls and boys becoming sexually active before marriage. To avoid premarital pregnancy, they suggest that contraception—likely oral pills and condoms—plays a role in preventing it, though there is a lack of open discussion about these practices. Sometimes, emergency contraceptive pills are also used to avoid unexpected pregnancy (Case 1). There we also found that if the girls need any information, support or services regarding contraception, they ask for help from neighbouring *Boudi* (See Case1).

Similar trends are found in other regions like Gaibandha, Bhola, and Khulna, where sexual relations among unmarried adolescents and youth and premarital pregnancy are not uncommon. Premarital pregnancy is often managed through menstrual regulation or hasty marriage arrangements (Case 11), highlighting the taboo surrounding family planning and the silence surrounding premarital sexual behaviour and pregnancy in certain communities.



Case 11

In a tea garden community, a boy and a girl were involved in a romantic relationship that eventually became sexual. One day, the girl's mother discovered that her daughter was already six to seven months pregnant—something the girl herself hadn't realised.

Upon learning she was pregnant, the girl urged the boy to marry her, even threatening self-harm if he refused, as she felt she had no other options. When the situation became public, a community meeting was called, and the elders, acting through a village court, decided that the couple should be married. Therefore, guardians from both families agreed and arranged their (boy and girl) marriage.

(FGD, Youth female, age 20, Sreemangal)

Another case in Gaibandha about premarital sex, unexpected pregnancy and sanction was described by a male respondent (Case 12).

Case 12

I have a cousin here in Gaibandha. He was romantically involved with a girl living near his residence. When he grew older, he found another girl and started another relationship that lasted for three years. In the meantime, he also continued his relationship with his first girlfriend and had sexual intimacy. When the first girlfriend put pressure on him to get married, my brother would not agree. As she did not take contraceptives, she found she was pregnant. Confronted with this unexpected incident, my cousin's family faced social pressure to marry them off. Then my cousin was compelled to marry his first girlfriend. (FGD, Adolescents Male, 10-19, Gaibandha)

When premarital sex results in pregnancy, menstrual regulation (MR) is frequently undertaken to address the issue, especially when families cannot arrange a marriage between the couple. While MR may provide an immediate solution, the deeper societal impacts are profound. The shame and stigma associated with premarital pregnancy can damage the reputation of the individuals involved, as well as their families, sometimes lingering for years. For young women, in particular, the social consequences can be severe, leading to emotional and

psychological distress. Judgement and isolation from the community often follow, making the situation even more challenging. The pressure to conceal these incidents, along with the reliance on discrete measures like visiting informal, local healers or pharmacists or midwives for MR, highlights the strong cultural taboos surrounding sexuality, marriage, and family honour in these regions.

Often these adolescent girls and boys remain traumatised when there is a pregnancy and are forced to marry. At a very young age, they are forced to take on adult responsibilities and roles, which neither are prepared to do so (Case 13).

Case 13

An adolescent girl from Rangamati got pregnant as she had a sexual relationship with her boyfriend. When she asked him to get married he did not agree. He refused and stated that it was not his child. Moreover, he had already fixed his marriage with another girl. So she asked for help from the local political organisation '*bichar*' & '*Salish*'; they decided in favour of her and forced him to marry her. (Youth, female, age 23, Rangamati)

These findings highlight the need for comprehensive FP education, with a particular emphasis on safe sex practices. There is also a significant need for interventions that provide young people with access to knowledge, contraceptive methods, and related services to reduce the risk of unintended pregnancies and sexually transmitted infections (STIs).

The discussion on contraceptive use among youth, coupled with cultural sensitivity, underscores the need for more accessible sexual and reproductive health education and open discussions on family planning options. However, access to contraceptives remains a challenge due to the prevalent culture of "moral policing." In many rural areas, local drug sellers (unlicensed pharmacies), influenced by conservative societal norms, often refuse to sell contraception to unmarried individuals. This restriction further limits young people's ability to practise safe sex and leaves them vulnerable to the consequences of inadequate family planning. The combination of restrictive cultural attitudes and limited access to contraception creates a significant barrier to reproductive health, amplifying the need for policy changes and

community-based programmes that ensure confidential and stigma-free access to FP services for all individuals, regardless of their marital status.

Addressing these barriers through educational initiatives, community engagement, and more inclusive health policies can help young people make informed decisions while reducing the negative social and health outcomes associated with unsafe sexual practices.

A 26-year-old male youth leader in Rangamati shared that-

“Once one of my friends made me buy contraceptive pills from the pharmacy for herself. At that time, I was not aware of the use of it. But I purchased it for her.” (KII, Youth Male Leader, age 26, Rangamati)

Among gender-diverse respondents in the study, all were unmarried, and most did not openly discuss their sexual relationships, possibly due to discomfort in disclosing their sexual identity or activities. Only one male respondent mentioned having a sexual relationship with his boyfriend but admitted that they did not use any protection, as they were unaware of safe sex practice and did not know whether it was necessary. This highlights a gap in sexual health education, particularly for gender-diverse individuals, who may lack the information needed to make informed decisions about protections from STD/STIs and safe sex practices.

The findings reinforce the need for more comprehensive sexual health education and the creation of supportive environments that allow young people to access information and services without fear of shame or lifelong adverse consequences. Breaking down these barriers can help reduce the stigma, empower young people to make informed choices, and promote a more understanding and compassionate approach to addressing premarital sexual relationships and their outcomes.

Shifting attitudes to family planning among married women/families

The study also observed shifting attitudes towards contraception, driven by increased education and the trend of delayed marriage. Respondents noted a growing preference for smaller families with 2-3 children and longer birth intervals. Despite ongoing challenges, the use of FP methods has become more widely accepted among married couples and continues to increase. Public

campaigns and communication efforts, alongside family planning programmes, have played a significant role in shaping these changes. Many individuals, such as a 24-year-old married woman from Gaibandha, expressed her awareness of FP, reflecting broader societal shifts toward family planning.

“In the past when people did not adopt any methods yet they used to have up to 9 children each. Now everyone is conscious they use a variety of contraceptive methods”.
(IDI, Youth Female, age 24, Gaibandha)

In Bhola and Rangamati, many married individuals reported that husbands use condoms to delay pregnancy. Notably, these respondents primarily belonged to higher educational and financially well-off backgrounds. A male respondent from the Chakma community, holding a master’s degree and working in the private sector, shared-

“I use condoms because we do not want a baby at the moment. We have mutually agreed to use condoms. . . We plan to have a child after three years, as we need to achieve financial stability first.. . we plan maximum two babies” (Married male, age 29, Rangamati)

There is a change in values, with couples now prioritising quality over quantity when it comes to having children. The desire for a male child has slightly reduced, contributing to fewer childbirths.

“Here as the government slogan says, whether a boy or a girl, two children are enough- they are trying to have two children (KII, Community People Male, 48, Sreemangal)

The current practice in different regions is for married women to start using contraception after their first child, with a shift in attitudes towards FP. Individuals who have been exposed to public health discussions are more open to accepting FP methods and knowledge. Although not everyone follows this approach, the overall trend shows a significant societal shift. People prioritise happiness, education, and stability over adhering to old rules about when to start a family.



Key Findings: Family Planning

1. Misconception about Family Planning (FP):

- Many respondents, particularly adolescents and youth, perceive FP as solely about ensuring family well-being and living together. The term "*jonmo niyontron*" (population control in Bangla) is understood to mean controlling pregnancies and childbirth or making a choice/decision about having a baby, linking FP to population control.

2. Knowledge Gaps in Contraception:

- Adolescents, unmarried males, and young married males have very poor knowledge about contraception compared to married women.
- Unmarried females have some level of knowledge about contraception, though less than married females.

3. Sources of Information:

- The primary sources of FP information for youth and adolescents are peer groups, mobile phones and the internet.
- Married females receive contraception information from female community members and health workers.

4. Cultural Taboos around FP:

- Open discussion about FP and contraception is considered taboo and shameful. People who talk about it are often labelled as a "bad" boy/girl (Bangla: '*kharap chele/meye*') or as someone who is overly mature ('*beshi peke geche*').
- As a result, even those who have information about FP, do not share it openly with others.
- Contraceptive use is often kept confidential and hidden due to shame associated with its use.

5. Increased Use of contraceptives

- Contraceptive use is increasing among married couples, despite cultural taboos.
- Premarital and extramarital sexual relationships are perceived to have increased,



but pregnancy out of extramarital affairs is less visible, possibly indicating more contraception use.

6. Religious Views on Contraception:

- From a religious leaders' perspective, the use of contraception is often not accepted. Many believe that it goes against God's will and is seen as a sinful act.

7. Beliefs About Contraception and Health:

- There is a widespread belief that using contraception can cause infertility and lead to other health problems.

8. Gendered Responsibility for Contraception:

- Most respondents, both male and female, perceive that women are responsible for using contraception to control pregnancy.
- As a result, wives often have no choice but to use contraception themselves.

9. Pressure on Married Women to Prove Fertility

- In many cases, married females face social and family pressure to prove their fertility by becoming pregnant within one year of marriage, though there is an expectation not to get pregnant within 4 to 6 months.
- After the birth of their first child, it is typically the female who takes responsibility for contraception.

10. Premarital and Extramarital Sexual Relations:

- Premarital and extramarital sexual relations are viewed as socially unacceptable and shameful acts. Thus, it is normatively expected that unmarried individuals do not need information or access to contraceptives.
- However, for those engaged in premarital sexual relations, the most commonly used contraceptives are condoms and emergency contraceptive pills.

11. Decision-Making in Contraceptive Use:

- Although some married respondents described making joint decisions about contraception use, the final decision typically results in the female taking the primary responsibility for contraception.

4.3 Menstruation

This section describes knowledge and perception about menstruation, irregular menstruation, and menstrual health management (MHM) and how people's beliefs and attitudes and social norms influence MHM practices among adolescent and youth girls in the study areas.

4.3.1. Knowledge and practices about menstruation among adolescents and youth

The findings from IDI, FGD and KIIs showed that respondents were familiar with the issue of menstruation, although they used different words in different regions, such as *Masik*, *Period*, *Menses*, *Rakto Jaowa*, *shorir kharap haowa*. Almost every female respondent who experienced menstruation mentioned that they knew nothing about menstruation before their first menses and they got information and learned about menstruation after experiencing menarche, while very few learned about it before. After experiencing menarche, they mainly got information about menstrual health management-related issues. Young girls, both married and unmarried, who have received training on SRHR or menstruation have a better understanding of the reasons and cycles of menstruation.

While some of the adolescent boys and most of the young males knew that girls started experiencing menstruation during adolescence but lacked proper knowledge on menstruation. They knew it as an illness (*shorir kharap*) of girls, which girls start experiencing from their adolescence.

“I heard, girls have some illness (rog) and they suffer from it after they reach a certain age. . . One of my female classmates told me that she became sick.” (Adolescent male, age 16, FGD, Gaibandha)

Adolescent and young girls in various areas, including Sreemangal, Gaibandha, Bhola, Khulna, Ranagamati, and Dhaka, primarily learned about menstruation and menstrual care from friends, peer groups, elders, mothers, sisters-in-law, grandmothers, and the internet, with some learning from textbooks. In Gaibandha and Rangamati, some high school girls received information from their teachers in classes who taught '*shastho shurokkha*' (Wellbeing) subject. However, none mentioned that they received information from any health-care practitioners (workers) from their locality. Although rural IDI and FGD respondents knew there were health centres in their localities, they never visited those centres to learn about menstruation from health

practitioners. Girls visit these centres for vaccinations, vitamins, and iron tablets, while some married girls visit for other health issues.

In four of the study areas namely Sreemangal, Gaibandha, Bhola, and Khulna, most adolescent and youth girls reported using clothes during their menstruation, while only a few revealed using sanitary napkins. Due to unaffordability and lack of awareness about menstrual hygiene, they could not use sanitary napkins. We found that female respondents from urban areas (Rangamati and Dhaka) mainly used sanitary napkins, as they belonged to relatively well-off families compared to rural areas and had exposure to menstrual hygiene-related knowledge. They often bought sanitary napkins by saving money from their own expenses and many do not ask their parents for money to buy it. Female respondents in gender-diverse communities (Dhaka) are mostly aware of menstrual health management and use sanitary napkins, as they belong to well-off families and have relatively good knowledge.

4.3.2 Attitudes, beliefs and norms related to menstruation

The findings from the FGDs, IDIs, and KIIs show that attitudes toward menstruation vary, heavily influenced by traditional beliefs and knowledge levels. Across different religious groups—Muslim, Hindu, Buddhist, and Sanatan (Adibashi)—a common trend is the tendency to keep menstruation a private matter, especially when a girl experiences her first period. Most respondents from these religious backgrounds believe that menstruation is not a topic for public discussion and prefer to keep it hidden, only sharing the information with close female relatives or friends.

However, an exception to this practice was found among the 'Tati' ethnic tribe residing in the tea garden area of Sreemangal, who follow the Sanatan religion. Unlike the broader cultural tendency to conceal menstruation, the Tati community celebrates a girl's first menstruation, marking it as an important milestone in her life. This celebration symbolises her transition into reproductive maturity, indicating that she is now seen as capable of engaging in sexual activity and bearing children. The community invites relatives and neighbours and organises a feast to commemorate this occasion.

Interestingly, while the celebration marks the girl's entry into womanhood, she herself is excluded from the public festivities. During the event, she is kept separate from others,

remaining at home, reflecting the complex mix of cultural reverence for her new status and the traditional taboos associated with menstruation. This practice illustrates the nuanced and sometimes contradictory attitudes towards menstruation—both as a private matter and, in some communities, a public milestone worthy of celebration.

In the study areas, deeply ingrained cultural and religious notions persistently cast menstruating women and girls as impure. This pervasive belief transcends religious boundaries—whether Hindu, Muslim, or otherwise—establishing widespread restrictions on their daily lives. As a result, during their menstrual cycles, women often find themselves excluded from certain household activities, religious spaces, or communal gatherings. They may be discouraged from handling food, cooking meals for others, participating in religious rituals, or even entering certain parts of their homes.

These perceptions not only shape how society views menstruating women but also significantly limit their autonomy and freedom. In many cases, social norms dictate that they remain physically separate and less active in community life for the duration of their periods. Such practices reinforce the idea that menstruation is a taboo, something to be concealed or managed discreetly, rather than acknowledged as a natural and healthy bodily function. The resulting stigma can contribute to feelings of shame, self-consciousness, and discomfort, ultimately affecting women's confidence, mobility, and participation in everyday social, religious, and economic activities.

Common Beliefs and Restrictions

In all the study sites, menstruation is often viewed as a time when women shed "dirty" or "impure" blood. Some communities even regard menstruation as a form of physical illness. This belief in impurity leads to several restrictions, limiting what women and girls can do during their periods. The following restrictions were reported across all the study areas-

Restrictions from religious perspectives: Menstruating women are prohibited from attending religious ceremonies, entering religious spaces, or participating in any rituals. For example, in Rangamati, girls are not allowed to visit temples like 'Mandir' or 'Pagoda' during their menstruation as they are considered impure.

An unmarried female youth leader who is currently working with an organisation described as follows,

“Girls can’t go to the pagodas; they can’t cook food for family members if they are menstruating. In our Chakma community, they are also not able to go to the Jhum cultivation sites... They believe it will harm the crops.” (KII, Youth Female, Unmarried, Youth Leader, Age 23, Rangamati)

Restrictions in doing household and domestic chores: Women are not permitted to handle food, participate in cooking, or perform regular domestic chores while menstruating (Case 14). In Hindu households, menstruating women may be barred from entering the kitchen or touching certain items, such as pickles. They may also be forbidden from sleeping during the daytime, wearing flowers, or talking loudly.

Case 14

Neelima (pseudonym) is a 17-year-old married girl in Khulna who was married a year ago. She experienced her first period at the age of 12. During her menstrual cycle, Neelima avoids eating sour foods, believing they cause heavier menstruation. She also refrains from leaving the house, considering menstruation a time for girls to remain confined and limit their activities.

She does not go to the kitchen and mandir during menstruation as her mother advises her that in this time, girls become impure, carry ‘bad blood’ and ‘supernatural thing’ may attack during evening time, so she does not go out of home in this time.

Restrictions in performing agricultural and fieldwork activities: In certain areas like Rangamati and Gaibandha, menstruating girls are not allowed to visit agricultural fields or crop stores. In the Chakma community, for example, women avoid collecting water from upper springs, as it is believed their presence will pollute the water.

Cultural and Religious Views on Menstruation

Muslim Communities: In Muslim households, menstruating women are not considered physically unclean, but they are viewed as ritually impure during their menstrual periods. This perception of impurity limits their participation in religious practices, such as prayer or fasting.

Hindu Communities: Hindu women face stricter restrictions during menstruation compared to the women of other religions. . They are not allowed to enter temples, kitchen or pooja-ghar (prayer room) at home, not touch any food prepared for auspicious ceremonies, or participate in religious rituals. They may also face limitations on their physical and social interactions, including refraining from touching other people or engaging in sexual activity. These taboos are closely linked to the belief that menstruation makes a woman's body impure.

Chakma Community: In the Chakma community, menstruating women face restrictions specific to their cultural practices. For instance, they are not allowed to visit the Jhum cultivation fields or collect water from certain sources, due to fears of polluting the crops or water.

Impact of Menstrual Taboos

The restrictions placed on menstruating women reflect the deep-rooted stigmas surrounding menstruation in these communities. These taboos limit adolescent girls and women's autonomy and restrict their ability to participate in daily life, perpetuating the idea that menstruation is a source of impurity or misfortune. Young and adult women are often marginalised during their periods, both within the home and in public spaces.

Overall, the findings highlight the urgent need for education and community-based interventions to challenge the cultural taboos and misconceptions surrounding menstruation. Addressing these beliefs can empower young and adult women to have greater freedom and dignity during their menstrual cycles, reducing the stigma they face and promoting more inclusive and supportive environments.

In both Gaibandha and Khulna, adolescent girls reported that their mobility was heavily restricted by their mothers and grandmothers during menstruation. Typically, they were confined to their homes for the first 2–3 days of their periods. This restriction reflects deep-

rooted social norms that associate menstruation with impurity, further isolating girls during this time.

Food-Related Taboos

Across multiple study areas, including Sreemangal, Gaibandha, Khulna, and Rangamati, cultural beliefs also imposed dietary restrictions on menstruating girls. These beliefs dictated that consuming spicy foods, fish, or meat could increase menstrual bleeding or intensify the smell of menstrual blood. As a result, girls were often excluded from consuming these foods during their periods. These taboos around food reflect the broader stigmatisation of menstruation and a lack of scientific understanding about menstrual health and hygiene.

Stigma Surrounding Menstrual Hygiene

In the study sites of Sreemangal, Gaibandha, Bhola, Khulna, and Rangamati, girls and women were discouraged from drying menstrual clothes in sunlight. There are two primary reasons for this:

1. Shame: The fear of others seeing menstrual clothes led to them being hidden away to dry in secret places.
2. Fear of Black Magic: Many respondents believed that menstrual clothes could be used for ‘kalo jadoo’ (black magic) if they were exposed. These clothes were considered “*oshubho*” (inauspicious), and there was a belief that if a man touched them, his lifespan would be reduced.

As a result, most girls and women used rags or cloths to absorb menstrual blood and dried them in hidden places out of fear and shame. This practice was also linked to concerns about men accidentally touching the clothes, which was believed to bring misfortune or harm.

“If I dry my clothes in sunlight that I used during my periods, my mother will ask me why I am drying these clothes outside of the house... Because people say that these clothes are ‘Ashuva’ it harms the people (especially men).” (IDI, Young Female, Degree level student, Age 23, Tea Garden, Sreemangal)

An uncommon stigmatised practice was revealed in the FGD with adolescent females in Bhola. They mentioned that in their community, people maintain several practices. A 16-year-old girl in the urban area of Bhola described her experiences as follows,

“We cannot cross a canal by jumping with mud in our hands... It’s a tradition in our community. Girls can’t touch tulsi trees and are not allowed to eat foods such as fish, chilli, bananas, cucumber, milk, and sour.” (FGD, Adolescent Female, Students, Age 15-17, Bhola)

4.3.2 Understandings, attitudes and beliefs about Irregular menstruation

The study found that most community members, both male and female, lack accurate knowledge about menstrual irregularities, including interruption of the menstrual cycle or periods over 35 days apart. This leads them to believe that the menstrual cycle is only interrupted when a female conceives a baby. For instance, during an in-depth interview with an unmarried female adolescent in Sreemangal shared her story and sufferings when she missed her period for three months (Case 15).

Case 15

A 23-year-old unmarried young woman lives with her parents, siblings, and grandmother in a tea garden community in Sreemangal. She is currently pursuing a degree-level education. Her father works in the tea garden, and her mother is a housewife. Since she first began menstruating, her entire family has been aware of her menstrual cycle. Her grandmother closely monitored her monthly periods. During menstruation, she was required to sleep separately and could not participate in religious rituals or enter the kitchen. These restrictions made it evident to everyone when she was menstruating.

However, about five or six years ago, she missed her period for two consecutive months. Her grandmother noticed this irregularity and informed her mother. Both became suspicious that she might have been sexually involved with someone. They scolded and insulted her, despite her attempts to prove that she had never engaged in any sexual relationship. Her grandmother even tried to check her pulse to determine if she was pregnant. They also



consulted a *kabiraj* (traditional healer), who examined her pulse and mistakenly concluded she was pregnant. This news was devastating for her and her family.

Eventually, her mother secretly visited a doctor, who confirmed that she was not pregnant but suffering from another health issue that had disrupted her menstrual cycle. After following the doctor's prescribed treatment for a month, her menstruation returned to normal.

(Youth Female, Unmarried, Student, Age 23, Sreemanagal)

In Bhola and Gaibandha, female respondents use the Bengali word '*Badhok*' to refer to irregular menstruation as well as women's infertility. So, when a girl (married or unmarried) faces such irregularities, they become very worried, particularly older female members (mainly mother or grandmother) that the girl may be infertile. Therefore, if any girl faces this problem, they primarily seek support from local healers secretly. Women and girls often visit *Kabiraj*, *Ojha*, for '*Pani pora*' as they believe they will be cured by drinking '*pora pani* (Verses recited from the Quran : Holy water)'. If the problem persists for a long time, then they go to the doctors.

Case 16 below describes an incident in which a girl experienced prolonged menstrual bleeding. Despite both her mother and father being well-educated, they chose to follow the potentially risky instructions of a local *kabiraj* (traditional healer) rather than seeking medical advice from a doctor.

Case 16

An eighteen-year-old girl experienced a prolonged menstrual period lasting eleven days, accompanied by heavy bleeding. Her mother consulted a *kabiraj*, who instructed the girl to refrain from eating for three days and to avoid speaking to anyone. Following these instructions made her weaker, and her mother prevented her friends from visiting. Concerned, the girl's friends informed her teacher. The teacher then persuaded the girl's father to take her to the hospital, where she was immediately admitted for proper medical care.

When we discussed this issue of menstrual regulation irregularities with gender-diverse youth (who are with a female body), they expressed that they did not face such problems but they knew some cases about their peers. These respondents informed that their peers usually go to doctors and seek treatment for it.

Key Findings: Menstruation

1. Lack of Proper Knowledge:

- Both girls and boys have limited or inadequate knowledge about menstruation. Most girls are uninformed prior to experiencing their first menstrual cycle, leaving them unprepared to manage the experience effectively.

2. Prevalence of Stigmas and Prejudices:

- Menstruation is associated with deeply rooted stigmas. Menstruating women are considered "polluted" or impure, leading to various social and religious restrictions. They are often prohibited from:
 - Performing regular household chores
 - Attending religious or cultural events
 - Participating in prayer and other spiritual practices

3. Negative Attitude Towards Discussion:

- Discussing menstruation is generally considered shameful and inappropriate. There is a strong societal belief that menstruation is a deeply personal issue, which should be kept hidden and never openly discussed. This reinforces the culture of silence around the topic.

4. Secrecy and Taboos:

- Menstruation is seen as something that should be handled in secret due to the shame and taboos surrounding it. This secrecy further isolates menstruating girls and women, contributing to feelings of shame and embarrassment.

5. Poor Menstrual Health Management (MHM):

- There is a widespread lack of healthy menstrual health management practices, often due to poor education and deeply ingrained cultural beliefs. Many girls and women resort to using unhygienic methods, such as rags, that are hidden from view, further compromising their health and dignity.

6. Reluctance to Seek Medical Help:

- Girls and women are hesitant to seek medical help for menstrual irregularities or related health issues due to the fear of being blamed for pregnancy or engaging in unaccepted sexual relations. This fear of shame and potential social judgement discourages them from addressing important health concerns.

4.4 Menstrual Regulation (MR)

This section describes knowledge and perception about menstrual regulation (MR) and how people's beliefs and attitudes and social norms influence MR practices among adolescent and youth girls in the study areas.

4.4.1 Knowledge about MR

Menstrual Regulation (MR) is a medical procedure used to induce menstruation and manage missed periods without confirming pregnancy. It can be performed through manual vacuum aspiration (MVA) or menstrual regulation with medication (MRM). In Bangladesh, 'abortion' or other Bangla local words are often used instead of 'MR'. We found in this study that both MRM and MVA methods are used to perform MR, so the study simply uses MR without specifying whether it is MVA or MRM.

The study reveals widespread stigma, secrecy, and negative attitudes toward MR, compounded by a lack of knowledge and access to safe services. The decision-making power of women regarding MR is significantly restricted by family and societal norms, while service providers' negative attitudes further exacerbate the barriers to safe MR practices.

Addressing these issues will require comprehensive education, community engagement, and efforts to reduce stigma and promote women's reproductive rights.

From interviews and FGDs, this study explored knowledge and perceptions on MR among adolescents (age 15 -17) and youth (age 18-30) males and females, in the six study areas in Sreemangal, Gaibandha, Bhola, Khulna, Rangamati, and Dhaka.

Usually, female respondents in IDI and FGDs who have studied beyond class 12? have an idea about Menstrual regulation (MR) referring to the Bengali term called 'Masik Niyomito Koran'. However, most of the other respondents from IDI and FGDs were not familiar with the terms MR or 'Mashik Niyomito Koran'. However, the respondents referred to it as 'Abortion' The naming of abortion in Bengali words varied from one area to another, such as *Gorvopat*, *Baccha Nosto Kora*, *Bachcha Fela*, *Pet fela*, *Wash Korano*, *Bacha Namano*, etc.

Among the gender-diverse community in Dhaka, we found that they knew about these terms and they also agreed that most of them first understood this term as 'abortion'. But they never heard that anyone from their peers used MR (performed abortion). Moreover, they thought that all adult people should know this issue and that services need to be available for all at a lower cost. They also think that taboos and stigma should not be there as it is a health issue, although they agreed that there are many negative health and social consequences associated with MR.

4.4.2 Practices of menstrual regulation

In the study areas, although respondents were aware of MR services available at nearby health facilities, such as Sadar Hospitals, Upazila Health Complexes, and private clinics, none reported personally using these services. Some young individuals and community members acknowledged the existence of MR services but emphasised the secrecy and confidentiality surrounding their use.

Women from different social backgrounds reportedly use various MR methods depending on their circumstances, but the issue is always handled discreetly to avoid stigma and judgement. As described by respondents, the typical approach involves first attempting abortion at home through the use of medicine or seeking help from informal healthcare providers, such as local doctors, "kabiraj" (traditional healers), or Ayurvedic practitioners. Only when these methods fail do they turn to formal healthcare institutions.

A 29-year-old married female respondent, working in a local development organisation in Rangamati, described the process, highlighting the deep-rooted stigma and fear of being exposed. She pointed out that even though MR services are available at formal health institutions, women often prefer to explore informal options first to maintain privacy and avoid social scrutiny. This practice illustrates the significant influence of societal norms on decision-making regarding MR, where secrecy and reliance on informal care are common strategies to manage the social repercussions associated with abortion.

A 29-year-old married female respondent who works in a local development organisation in Rangamati, described as follows,

“Many people use medicine for abortion from Boidya (traditional healer) or local doctors; however, if the pregnancy situation is complicated then they go to the hospital for abortion...” (KII, Youth Female, Married, Social worker, Age 29, Urban Rangamati)

Respondents mentioned that access to MR services is not consistently available in all regions of the study sites. Due to the significant stigma surrounding MR, many women resort to informal and unregulated settings for the procedure. These informal settings are typically managed by untrained individuals, which often results in risky and unsafe situations for women.

A 23-year-old female student who works for a local NGO and volunteers at the RHRN programme in Sreemangal shared her observations about how women in her community handle MR. As she described,

“... Some women know about ‘Bonoji Osud’ (Ayurvedic Medicine), which is made from plants and herbs to terminate the fetus... If it doesn't work properly, sometimes they buy pills from the pharmacy that are used for abortion by someone else.” (IDI, Youth Female, Working in a local NGO, Unmarried, Age 23, Sreemangal)

She explained that some women first attempt to abort by using Ayurvedic medicine, a traditional herbal remedy. If this approach fails, they often turn to purchasing medical MR pills (usually respondents named it as ‘abortion pill’) from local pharmacies. Sometimes local doctors prescribed these pills but doctors did not usually inform about the consequences and side effects. This self-managed process, often done without medical supervision, raises health

risks considerably and can lead to post abortion complications, which can be fatal. The reliance on untrained providers or over-the-counter medication increases the likelihood of incomplete or unsafe procedures, further complicating access to safe reproductive healthcare. This account underscores the urgent need for more accessible, safe, and stigma-free MR services to prevent women from seeking dangerous alternatives in informal settings.

In another interview, a 24-year-old married female in urban Gaibandha learned from others that women use abortion pills and MR methods (usually called ‘wash kora’ or abortion) to abort a child. But she could not mention the name of the pills (medicine). As she described,

“It can do it by using abortion pills and there is also the MR method. I don’t know about that, but I heard that a pipe being pushed into the uterus is like an injection. By pushing this pipe, they (doctors) remove the embryo from the uterus.” (IDI, Youth Female, Married, Student and Homemaker, Age 24, Urban Gaibandha)

4.4.3 Attitudes towards MR services

A significant issue identified in the study is the deep concern over privacy and secrecy when seeking MR services, driven by fear of community judgement. Many individuals prefer to first approach local healers, such as “*kabiraj*” (traditional healers), because it allows them to maintain a level of discretion that visiting formal health centres might not. This secrecy leads to risky situations where untrained practitioners manage MR procedures, which often fail or result in complications.

If the initial attempts with local healers do not yield the desired results, these individuals often turn to professional healthcare providers, such as “*dhatiri*” (traditional birth attendants), community-based health workers, or doctors. However, by this time, they may already have compromised their health condition due to ineffective or unsafe methods.

Unmarried adolescents and young girls, who are especially vulnerable to social stigma and fear ostracism, prefer to seek MR services from health centres located far from their communities to avoid being recognised. In contrast, married women are less concerned about defamation and typically choose to visit local hospitals or clinics.

In Sreemangal and Rangamati, the study found specific cases of unmarried pregnancies where young girls attempted to perform MR procedures at home with the help of “*dhatiri*” (traditional

birth attendants), “*boiddya*” or “*kabiraj*” (traditional healer) to keep it hidden from their community.

Since these abortions are performed in secret, people rarely discuss them openly. Instead, they become the subject of common gossip. A 22-year-old unmarried girl from Sreemangal describes one such incident, where a woman attempted to abort her pregnancy at home. The incidents are as follows:

“... There was a Boudi (sister-in-law) who died during an abortion. The incident happened nearly two years ago... She knew about her pregnancy after 4 months and she tried a riskier abortion at her home and the accident happened.” (IDI, Youth Female, Unmarried, Age 22, Sreemangal)

These cases highlight the extreme lengths individuals will go to in order to avoid societal shame, even when it puts their health at serious risk. It underscores the importance of addressing both the stigma associated with unplanned pregnancies and the lack of accessible, safe MR services. Ensuring that women—particularly unmarried girls—can seek proper care without fear of judgment or harm is critical. In a FGD in Sreemangal, one young female respondent shared a story about seeking help from a neighbour, which is described in Case 1. Due to the fear of losing honour, many girls and women turn to private clinics or traditional healers to terminate an unexpected pregnancy. This pattern was noted multiple times in our study.

Health Service Providers’ Attitude

In all six study areas, a recurring pattern was noticed: unmarried girls and young women opt to undergo MR procedures in the privacy of their own homes. This occurs with the assistance of *dhatris* (traditional birth attendants), who provide medications and discreet support. Additionally, in places such as Gaibandha, Bhola, and Dumuria upazila in Khulna, female respondents informed that women sometimes seek MR services from private, clandestine clinics and diagnostic centres to end unwanted pregnancies without having it known.

However, access to reliable MR services remains unreliable and inconsistent. Many trained service providers, for various reasons—ranging from personal discomfort for religious reasons to fear of social repercussions, refuse to offer these procedures to clients. Consequently, women

who wish to terminate an unwanted pregnancy often find themselves relying on informal networks and unauthorised facilities, which may heighten their vulnerability and limit the safety and quality of the care they receive (Case 17).

Case 17

In Sreemangal, a case was reported where a female gynaecologist refused to perform MR on an unmarried adolescent girl from a nearby tea garden, citing that it would be a sin, which the doctor could not morally commit. Thereafter, this doctor referred that girl to another private doctor and the girl used services from that referral point. This refusal highlights the moral and religious conflicts healthcare providers share in justifying their refusal, further complicating access to MR services. (FGD, young girl, age 22, Sreemangal)

The resistance to MR among some service providers in all three regions of Gaibandha, Sreemangal and Bhola, rooted in religious beliefs, particularly following religious pilgrimages like Hajj, emphasises a significant challenge in implementing reproductive health services.

During an interview with service providers in Gaibandha reported-

“Many of the health workers do not feel comfortable providing MR services even though they have training and it is their job. When a client comes to our service centres, we try to convince them not to abort the foetus. They rather ask them to find an option which would not make them abort. It may be marriage in the case of unmarried couples or keeping the baby for married couples.” (Male service provider, age 42, Gaibandha)

One married girl in FGD also shared a story of her neighbour who faced challenges to seek MR services due to service provider's negative attitudes (Case 18).

Case 18

Rumi (pseudonym), 21, was married at the age of 15 and gave birth to her first child within a year of marriage. She is now a mother of two. Three months after the birth of her second child, Rumi discovered she was pregnant again—a pregnancy she did not want due to her poor health and the young ages of her other children.

When Rumi sought help at a government hospital, she encountered harsh and unsympathetic behaviour from the doctor. The doctor questioned her decisions, saying, "Why did you get pregnant again? Why didn't you notice earlier? Why didn't you control your sexual urge and activity? Why didn't you use contraception?"

The doctor further suggested consulting her family about keeping the child. Although Rumi eventually underwent an MR, she was subjected to considerable judgment and criticism from both the doctors and nurses throughout the process.

(FGD, married young girl, age 27, Bhola)

The perception of MR as "equivalent to murder" highlights the intersection of cultural, religious, and moral beliefs that complicate the provision of essential reproductive health services. It reflects a strict interpretation of religious doctrines, leading to moral dilemmas for service providers, reducing their willingness to perform MR procedures. This can create disparities in service availability, especially in regions with few healthcare providers, limiting access for women who need them.

Stigmatisation of MR and associating it with sin or murder deters women from seeking services even when legally entitled or medically necessary. Women may fear judgment or social ostracism if they pursue MR, further complicating access to care. Even if national policies may support MR as part of reproductive health services, implementation faces challenges due to resistance from service providers influenced by personal or community beliefs.

A 23-year-old unmarried girl from Sreemangal shared that in the tea garden area, health workers can only provide consultative advice regarding MR services, but women are unable to access the actual services due to a lack of resources and availability of doctors in the tea garden's health centre. As a result, women needing MR services must go to Sadar Hospital for the procedure. The limited availability of MR services, combined with moral and religious opposition from health workers, creates significant barriers to accessing safe and legal MR for unmarried adolescent girls in these areas. As she shared,

“People (females) do not perform MR at tea garden health centres. It's only performed at the Sadar Hospital... Married women can seek advice from the health workers who work in tea gardens but there is no doctor available to perform MR... Besides, unmarried women prefer to keep it a secret, so they do not go to the garden health centre. They also go to the district hospital.” (IDI, Youth Female, Unmarried, Age 23, Working in a local NGO, Sreemangal)

4.4.4 Beliefs, social norms and its influence on MR practices

From IDIs, FGDs and KIIs with the respondents in all six of our study areas, it becomes apparent that people have some particular beliefs and negative attitudes towards MR. This section will describe a variety of attitudes, beliefs and some common social norms regarding MR.

Religious beliefs and attitude towards MR:

Abortion is generally viewed as an immoral and a sin, as like 'killing a life'. The respondents, including Muslims, Hindus, and Buddhists, all shared that abortion is a sinful act since it ends a potential new life on earth. To them, Allah is the creator and the sustainer of the universe. So, only he can decide the lives and deaths of living things and they believe that the Almighty gives life to the earth, and people have no right to end the creations from Him. According to them, “MR/abortion is ‘Haram’ (forbidden) in Islam” and “that the almighty is the ultimate provider of ‘Rizq’ (sustenance) so people shouldn't kill a life out of fear of poverty.

However, Key Informants from community people and religious leaders mentioned that there is guidance in the holy Quran to avoid abortion but one exemption is also mentioned, which is that abortion will only be performed if the life of a mother is at risk. Another KII in Gaibandha, who is a school teacher also echoed-

“The message is clear – if you haven't conceived, it's not a sin, but if you have, precautions are necessary, as abortion would be considered a sin.” (influential person, age 64, Gaibandha)

Likewise, a 45-year-old mother from the ‘Ganju community’ who follows the Sanatan religion in Sreemangal shared that after she learned that killing a child is an offence and sin in her faith, she informed everyone to use contraception rather than MR/abortion. As she said,

“Killing a child (abortion) is a sin... When I learned and understood this, I informed everyone in my community and suggested they use available contraceptive methods, not abortion.” (KII, Mother, Ganju Community, Ichamati Tea Garden Worker, Age 45, Sreemangal)

“Children are considered a gift from God, and no one has the right to kill or abort a child; it will count as a great sin. Buddhism does not approve of killing life on earth. If someone kills a life, then they will be punished both on earth and in the afterlife. . . In our Tripitaka (the sacred book of Buddhism), it is written that killing a child is a sin...” (KII, Faith Leader/Monk, Age 60, Rangamati)

All respondents from each religious belief expressed that terminating a foetus is not morally acceptable. Therefore, to avoid unexpected pregnancy and abortion, relatives or peers suggest using contraception.

“In our religion, abortion is also forbidden. It's a sin... People encourage using contraceptive methods to avoid pregnancy and abortion.” (FGD, Adolescent Female, Unmarried, Age 15-17, Kakiachara tea Garden, Sreemangal)

MR among married girls: community people's attitudes and practices:

Social norms often place married women as mothers, assuming it is their responsibility not to abort a child. In six study sites, it is not socially acceptable for a woman to give birth if they are 40 to 50 years old. If she conceives after this stage or her children are older, it can lead to social awkwardness, embarrassment, bullying, and shaming within the family and community. Particularly in Gaibandha, Bhola, and Khulna, respondents reported instances where late pregnancies were subject to social bullying and shaming, prompting some women to opt for MR with their husbands' consent before the news spreads widely. Women of this age group are not expected to be sexually active in their marriage. For instance, a married female shared an incident in a tea garden area of Sreemangal (Case 19) as follows-



Case 19

A married woman (45) in a tea garden had two children who were college students. One day, she understood that she had become pregnant. So, she felt very nervous and worried, because if people knew information about her late pregnancy, then they would criticise and bully and shame her. She immediately shared the issue with her husband and both of them agreed to abort the child. Then the woman acted like she had become sick and her husband took her to the district Sadar Hospital in Moulvibazar. They aborted the child; however, during the MR procedures, due to some health complications, the woman died in the hospital. After the death, people in the community found out about the incident. (IDI, Youth Female, Unmarried, Age 19, Sreemanagal)

In the study areas, particularly Gaibandha, Bhola, and Khulna, two distinct patterns of MR practices were identified. Firstly, some women become pregnant shortly after giving birth, facing health risks and challenges in caring for two children simultaneously. This led to social criticism, prompting some mothers to undergo MR to address birth spacing concerns. In Bhola, this situation is referred to as '*Muraay*' in the local Bengali language, and in such cases, mothers undergo MR.

Secondly, in Sreemangal, Gaibandha, Bhola, Khulna, and Rangamati, if a woman conceives within the first six months of marriage, she may be suspected of having had a premarital sexual relationship. To avoid suspicion and stigma from her husband and in-laws, some women secretly seek MR to terminate the pregnancy. According to a 62-year-old retired male teacher from Gaibandha stated-

“Chaos will occur in her family... They will start assuming that she might have had a relationship before her marriage. The husband will misunderstand them by thinking, ‘I got married only three months earlier. How does my wife become pregnant this time? The baby is not mine, and she is Aswati (a bad character). (KII, retired male teacher, age 62, Urban Gaibandha)

In Sreemangal and Rangamati, an exception was noted where parents and family members are prohibited from performing MR for the first child. There's a prevalent belief that aborting the

first child could lead to infertility in the future. Surgical abortion is also avoided due to concerns about increased health complications for adolescent girls and women.

However, in Khulna, Gaibandha, and Bhola, early marriages often lead to pregnancies in girls under 18, posing serious health risks. In these cases, families prioritise abortion to safeguard the girls' lives, recognising the urgent need to address health challenges associated with early pregnancies.

Married women typically cannot decide on their own and require consent from their husbands, as well as approval from parents, grandparents, and other family members. Mothers often believe that children strengthen a woman's position in her husband's family, and this discourages MR or undertaking an abortion. Similarly, in-law's families may oppose these procedures, viewing the unborn child as part of their lineage.

Decisions are also influenced by the gender of the expected child. Pressure to maintain family hierarchy may lead to reluctance to abort pregnancies if the child is anticipated to be a boy. Conversely, if a couple already has two or more girls and expects another girl, they may consider abortion with the approval of elder family members. However, if a boy is expected, families are less likely to approve abortion. In some areas, doctors withhold information about the child's gender to prevent couples from rejecting female children, especially if they already have daughters. This is not common but was mentioned.

“In some cases, doctors do not inform the gender of the child if it's a girl... They know many people do not want to have more girls. So, in that case, they and their family members prefer to abort the child.” (FGD, Youth Female, Unmarried, Age 19–26, Gaibandha)

Menstrual regulation among unmarried and adolescent girls: Attitudes and practices

In the six study areas, adolescents and youth were found to be frequently involved in romantic relationships, sometimes leading to premarital sexual intimacy. All respondents irrespective of area, gender, and age, mainly youth, parents, and community people cited increased access to mobile phones and the internet facilitating wider communication among individuals as the main reasons for this trend. In all study areas, the key informants, including parents and programme personnel, shared that it is hard to control the younger generation from refraining

from romantic relationships as they feel more attraction to one another at this age. These romantic relationships sometimes result in accidental pregnancies.

If an adolescent girl engages in premarital sex, it's shameful for them and their parents as well. Community members blame their parents as they failed to guide and control their children, and at the same time, they use the label '*noshto chele meye*' (immoral boys and girls). If an adolescent girl is found to have been pregnant, it brings more shame to them and families. For instance, an adolescent boy described during a focus group discussion that neighbours, relatives and community members would humiliate not only the adolescent girl but also her family members, if she was pregnant..

"When a girl in our community commits this sin (premarital pregnancy), everyone, including neighbours, relatives, and community members, criticises her and her family. This leads to social shaming and embarrassment for the girl and her family." (FGD, Adolescent Male, Unmarried, Age 15-17, Gaibandha)

If a girl gets pregnant before marriage, parents may attempt to resolve the situation by arranging a marriage to the male, but if no solution is found, they may opt for abortion to protect their daughters' and family's honour. In contrast, a boy may face some criticism, but his reputation is less tainted compared to girls. Community people shared that adolescent boys may want to fulfil their sexual desires, but it was up to adolescent girls who must control themselves from engaging in sexual relationships. As being pregnant before marriage and performing MR is socially taboo, community members shared that unmarried girls and women choose to have abortions and use the MR service in secrecy. So, they never disclose these pregnancies to avoid their criticism and judgement and loss of reputation.

"Community members are not ready to accept abortion and killing a child... It's true; even in some cases, their family members also do not support this. So, if they need to perform an abortion, they do it secretly." (IDI, Youth Male, Unmarried, Age 24, Gaibandha)

We found a few cases (Case 20, below) which found that a girl in Sreemangal tea garden became pregnant without marriage and faced rejection from the adolescent boy and his family.

Case 20

In a village near the tea gardens of Sreemangal three to four years ago, an incident occurred where an adolescent girl became pregnant after having a premarital sexual relationship with an adolescent boy. The news of this incident spread throughout the village. The girl's parents attempted to persuade the boy's family to approve of their wedding, but the boy and his family members rejected the proposal and suggested aborting the child. The boy's family eventually agreed to the wedding due to social pressure and took the girl to their home. However, after taking the girl to their home, they delayed the marriage till the child was born and then despite their earlier commitment, they sent the girl back to her family without getting them married. The boy's family kept the baby in their home. (Adolescent Girl, Unmarried, Age 17, Kakiyachora Union, Sreemanagal)

A similar case (Case 21) was described in Rangamati by a girl-

Case 21

A Chakma adolescent girl and adolescent boy were in a romantic relationship and the girl became pregnant, and this information spread within the community. A "Salish" (local social judgement with community leaders) was held, but the leaders were unable to facilitate an agreement between the two families. The adolescent boy declined to marry the girl, and as a last resort, the girl's parents considered terminating the pregnancy. However, the abortion was averted when the boy's mother proposed an alternative solution that they would take care of the child. After that, the girl went to her boyfriend's house and gave birth to a male baby. The mother of the boy took all of the responsibilities of the newborn. After spending six months, the girl came back to her parental house leaving her baby at her boyfriend's home. (Youth girl, 24 year, social development Volunteer, Rangamati)

Therefore, it reveals that unmarried girls in Bangladesh face significant challenges if they become pregnant, due to deeply entrenched cultural and societal norms. Addressing these requires comprehensive interventions like SRH education, quality health services maintaining privacy and confidentiality, and social programmes to reduce stigma.

Key Findings: Menstrual Regulation

The findings highlight critical barriers and attitudes surrounding Menstrual Regulation (MR) in Bangladesh, particularly among adolescents and youth. Below is a summary of the key points:

1. Contextualisation of the terminology: programme designers to contextualise the language and approach, which will be used when implementing CSE, FP, and MR initiatives to address these deeply held culturally sensitive issues. Programmes should focus on engaging communities, parents, and religious leaders to shift harmful norms and promote informed, positive practices among youth.
2. Limited Knowledge and Awareness
 - MR as an Unfamiliar Term: While abortion is a familiar concept for both youth and married individuals, adolescents are largely unaware of the medical term MR. Among adolescents and youth, only a few—mostly married or those exposed to Sexual and Reproductive Health and Rights (SRHR) training—have a limited understanding of MR. They have local terms such as *wash kora*, *bachcha phelano*, *pet namano*, *bachcha noshto kora*, etc.
 - Lack of Adequate Knowledge: Adolescents and youth, especially those outside of formal SRHR training, have minimal or no knowledge about MR. This knowledge gap contributes to limited understanding and misconceptions about its purpose and use.
3. Social Stigma and Shame



- Discussion of MR: Talking about MR is socially unacceptable and carries a stigma, as it is often assumed that anyone discussing MR has personal experience with abortion. This leads to secrecy and silence surrounding MR-related topics.
- Perception of Abortion: MR is often equated with abortion, and abortion is viewed as a sinful act that kills lives. Respondents from all demographics—regardless of age, community, profession, or gender—expressed overwhelmingly negative attitudes toward MR.

4. Secrecy and Social Shaming

- MR Practices: MR is performed secretly to avoid the intense social shaming that accompanies the procedure. This applies to both formal healthcare settings and informal methods of seeking care.
- Acceptance of MR: The practice of MR is widely stigmatised and considered shameful, particularly for unmarried individuals. For married women, MR is only accepted under certain conditions, such as serious health risks to the mother or child, or in cases of premarital pregnancy where no other alternative (e.g., marriage) exists. However, there is a shifting attitude, such as respondents from GDC mentioned that need based MR services should be accessible.

5. Variations in Acceptance

- Different Attitudes for Married vs. Unmarried Women: Acceptance of MR differs significantly between married and unmarried women. For married women, MR is rarely discussed or accepted except in limited circumstances, while for unmarried women, it is only considered when premarital pregnancy occurs and no alternative (such as marriage) is possible.
- Geographical Differences: There is a slight degree of acceptance of MR in specific regions such as Sreemangal and Rangamati. However, this acceptance is still minimal.

6. Challenges in Access to Safe Services



- Limited Availability of Safe MR Services: Safe MR services are not readily available, and when they are, service providers often hold negative attitudes and may be judgmental towards clients seeking MR.
 - Healthcare Provider Bias Many healthcare providers exhibit biases against MR, further complicating access to safe and non-judgmental care. This increases the likelihood of women seeking unsafe alternatives or delaying critical care.
7. Lack of Female Decision-Making Power
- Influence of Family and Husbands: Women rarely make the decision to undergo MR independently. The decision is often influenced or controlled by family members, husbands, or in-laws, limiting women's autonomy over their own reproductive health choices.

5. Social norms identified in this research

This research study identified some social norms associated with CSE, family planning and menstrual regulation issues in Bangladesh, as described below. This section describes how these social norms often create barriers that restrict open discussion and informed decision-making regarding sexual and reproductive health and how these impact health behavior and service-seeking practices. Thus, the intersection of cultural, religious, political and gender norms significantly influence the accessibility, acceptance and practices related to CSE, FP, and MR.

This subsection of social norms has been identified as below:

- i. Social norms around CSE
- ii. Social norms around FP
- iii. Social norms around Menstrual Regulation

6.1 Social norms around CSE

The research study outlines several critical social norms regarding CSE in Bangladesh, revealing the complexities and challenges in its implementation.

6.1.1 Perception and attitudes towards CSE

Conservative ways of thinking still persist in shaping how social norms are practised among the community as to what can be taught, how much can the teacher talk about in the classroom and up to what extent can adolescents be informed about SRH issues. In addition, because there is a cultural taboo around talking about ‘sexuality’ openly, CSE discussions face social sanctions.

- Perception of CSE: CSE is often perceived narrowly as synonymous with discussions about sex and sexual intercourse. This misunderstanding leads many parents and



community members to oppose CSE, fearing it may influence their children negatively.

- Terminology barrier: The term "comprehensive sexuality education" itself serves as an obstacle, resulting in restrictive attitudes towards discussing broader aspects of sexual and reproductive health.
 - As CSE terminology creates some misperception, (i.e., education about sexual relations), these terms may be avoided and 'Health education' may be used in advocacy and communication.
- Acceptable topics: While discussions about puberty and menstrual hygiene management are generally accepted, topics such as sexual reproduction and contraception are viewed as inappropriate. The community tends to be more accepting of discussions related to hygiene, health, and issues like gender-based violence and child marriage, but only within the context of puberty.
- Gender segregation: Many community members prefer separate education sessions for boys and girls, indicating discomfort with co-ed environments for discussing CSE. This reflects broader restricting societal norms concerning gender and education.

6.1.2 Resistance to teachers teaching CSE

Teachers are traditionally seen as honourable and respectable figures responsible for imparting moral and academic knowledge. However, many parents and community members believe that teachers should not teach CSE, often equating it with education about sexual intercourse. Similarly, community people perceive school as a sacred place where students should not learn 'sexuality', 'sexual intercourse' related issues, and CSE does promote these learnings. This perception creates significant resistance to-

- Parents and community: They generally believe that exposing children to CSE topics is inappropriate, particularly in a school environment. Many hold the view that teachers should refrain from including these subjects in classroom discussions. Instead, they argue that boys and girls will naturally acquire the necessary knowledge about sexual health and relationships as they mature, without any formal instruction.



- Teachers: Many teachers echo these sentiments, feeling that teaching sexuality does not fall within their purview as educators. Even those who have received training on SRHR or CSE often remain unconvinced about their role in delivering this content. Instead, they view it as a sensitive topic best left to parents or learned informally as children grow older, rather than something to be formally addressed in the school curriculum.

6.1.3 Limited scope of CSE in practice

Many teachers focus on topics related to puberty and basic health issues, avoiding discussions on contraception, pregnancy, or sexuality. Some provide contraception advice to married girls but caution them not to share it with unmarried peers. Due to insufficient training, delivery skills, stigma and taboo many teachers are unsure about the appropriate depth and range of information to offer.

Teachers who engage with CSE:

- Restrict conversations to puberty and basic health information: There is a societal expectation to limit discussions around non-controversial topics like puberty, menstruation, etc. while avoiding sensitive subjects like contraceptives, sexuality, etc.
- Advice for contraception to married girls: Providing contraception-related advice to married girls is seen as acceptable, reinforcing the social norm that sexual activity and family planning should only be discussed within the context of marriage.
- Secrecy about contraception for unmarried individuals: Married girls are advised not to share contraception information with unmarried peers, highlighting the societal belief that topics like contraception and sexual health are not appropriate for unmarried individuals.
- Inadequate training for teachers: The lack of comprehensive training, skills and technique to deliver sensitive information suggests that societal norms prevent educators from providing more thorough and open discussions on sexual health, leading to uncertainty about the appropriate level of information to share.

6.1.4 Varied acceptance among parents and communities

Parents and community members are uncomfortable with CSE going beyond discussions about puberty. This reflects a broader cultural reluctance to openly discuss sexual health in more comprehensive terms.

- Support for limited CSE: Parents exposed to CSE education or NGO interventions show partial acceptance but advocate for limiting the content to puberty, menstrual hygiene, and basic health. They believe that discussing topics like sex, sexual intercourse, and contraceptives could encourage adolescents to experiment with premarital sexual relationships.
- Opposition to comprehensive content: Most parents remain uncomfortable with CSE extending beyond pubertal changes-related topics. There is a societal expectation that sexual health education should be limited to basic topics like puberty and physical changes, with many parents feeling uneasy about addressing more detailed subjects.

6.1.5 Perspectives from youth

- Youth groups affiliated with the RHRN2 programme recognise the importance of teaching CSE in schools and through peer-learning sessions. They emphasise that content should be age-appropriate and sensitive to gender and marital status.

All of these insights suggest a need for targeted efforts to clarify what CSE encompasses, address misconceptions, and create a supportive environment for discussing these vital topics in a manner that respects cultural sensitivities. By addressing these challenges holistically, Bangladesh can develop and implement effective CSE programmes that meet the needs of adolescents while respecting cultural and social contexts.

6.2 Social norms around FP

The research study explores attitudes and social norms related to family planning discussions and the use of contraception. Although there have been changes in practices, many restrictive norms and attitudes still prevail significantly across communities.

6.2.1 FP - A taboo topic for open discussion

Bangladesh has made substantial progress in promoting family planning (FP) and contraceptive use as part of its population control initiatives and efforts to improve maternal and child health. Although the use of contraception has increased and total fertility rates have decreased over the past few decades, deep-rooted cultural and societal norms, taboos, and stigma present significant barriers to open discussions about family planning and contraception use, particularly in conservative and rural communities.

- **FP and Its Association with Sexual Relations:** FP methods are inherently linked to sexual intercourse, which is considered a private matter. As a result, conversations about FP are limited to specific contexts and groups and only acceptable within marriage and married individuals, but, not among unmarried individuals.

Restricted social circles for FP conversations

- Married women primarily discuss FP methods within close, trusted circles, such as with their sister-in-law (ja), neighbouring similar-aged married women or elder sister but not in public.
- Open discussions are discouraged, and family planning conversations among unmarried individuals are particularly stigmatised.

Challenges and implications

Lack of open discussion about family planning limits access to information and creates barriers to widespread understanding and acceptance of FP methods. Contraception and pregnancy management are seen as the sole responsibility of women, reflecting gendered perceptions of reproduction. Decision-making lies with the husbands, avoiding seeking their wives' consent to maintain control. Although traditional attitudes persist, there are signs of gradual shifts challenging these norms.

6.2.2 Females as Solely Responsible for Contraception and Pregnancy Management:

- **Gendered Perception:** Contraception use is perceived as primarily a female responsibility, as reproduction is often viewed as a "female issue."



- **Male Dominance in Decision-Making:** Husbands largely make the decisions regarding contraception, with wives playing a dependent role. Women's autonomy in reproductive decisions is limited, reflecting entrenched gender norms.
- **Lack of Consent-Seeking:** Men avoid seeking their wives' consent in decision-making, fearing it might compromise their dominance.

Progressive Changes: While these traditional attitudes persist, there is evidence of gradual shifts challenging these hegemonic norms.

6.2.3. Role of female fp workers:

- **Restricted access to males:** Female health workers primarily provide family planning services to women in households but face significant barriers in interacting with male clients. Couple counseling is rare, leaving men ill-informed or misinformed, which restricts their use of contraception.
- **Hesitation in discussions:** Cultural sensitivities prevent female health workers from openly discussing family planning with men, further reinforcing gender-based barriers.

6.2.4. Sexual activity among adolescents and youth:

- **Social restrictive norms against premarital sexual relationships:** Adolescence is a time marked by curiosity and exploration, including sexual curiosity. Despite societal restrictions against premarital sex, some unmarried adolescents and youth may still engage in sexual activities.
- **Conflict with norms:** The societal taboo against premarital sex creates a challenging environment for young people, who may face stigma or lack of access to sexual education and reproductive health services.

These findings underscore the complex interplay of gender norms, cultural expectations, and societal restrictions in shaping SRH practices and behaviours in Bangladesh. Addressing these issues require culturally sensitive approaches that promote gender equity, enhance male

engagement, and improve access to sexual and reproductive health education and services for both genders and all age groups.

6.2.5. Religious beliefs and contraception use:

Religious and cultural beliefs significantly shape attitudes toward family planning. Many regard children as divine gifts, causing resistance to artificial contraceptive methods, seen as contradicting God's will. Although Islamic teachings do not explicitly prohibit contraception, varied interpretations among religious leaders and individuals often lead to opposition, reflecting deep moral and spiritual concerns around controlling reproduction.

- **God's will vs. artificial methods:** Family planning is often viewed through a religious or traditional lens, which limits broader acceptance. Religious beliefs often frame attitudes toward contraception, with many perceiving children as gifts from God. While Islamic teachings do not explicitly prohibit contraception, varying interpretations among religious leaders and individuals lead to opposition to artificial family planning methods.
- **Moral and Spiritual Concerns:** The idea that controlling reproduction artificially contradicts divine will is deeply rooted, influencing individual and community-level decisions on family planning.

6.2.6. Cultural emphasis on family values:

In some communities, large families are seen as a source of pride and blessing, discouraging the use of contraception. Nonetheless, changing economic realities and a growing appreciation for the benefits of smaller families are gradually influencing a shift toward more widespread acceptance of family planning.

- **Large families as a source of pride:**
In some communities, having a large family is associated with blessings, pride, and family strength. These values often discourage the adoption of contraception or family planning practices.
- **Shifting Preferences:**
Although traditional attitudes favor large families, there is a gradual shift toward

smaller families, driven by economic factors and increased awareness of the benefits of family planning.

6.2.7. Stigma around contraception Use:

Societal stigma, often rooted in cultural taboos, misinformation, or fear of judgment, remains a major barrier to contraception use and openness. This is especially dominant in conservative or rural areas, where community perceptions strongly influence personal decisions, leading to reduced access to family planning services.

- Social and cultural stigma: Despite significant government efforts to promote family planning, societal stigma continues to deter individuals from using or openly seeking contraception. This stigma may stem from cultural taboos, misinformation, or fear of judgment within the community.
- Barriers to accessing services: Stigma can lead to hesitation in accessing family planning services, particularly in conservative or rural areas, where community perceptions play a significant role in personal decision-making.

These insights reflect the need for culturally sensitive approaches that integrate religious and social values while promoting reproductive health and family planning.

The study highlights the cultural and societal norms that significantly restrict contraception-related discussions and usage among unmarried individuals and older adults in Bangladesh.

6.2.8. Social norms on contraception and unmarried individuals:

Premarital sex is widely condemned, limiting open dialogue about family planning for the unmarried. Using contraception outside marriage is stigmatized as endorsing forbidden behaviour, hindering access. Despite rising premarital sexual activity, societal disapproval deters unmarried youth from seeking contraception. Lack of tailored reproductive health services further compounds these challenges for unmarried individuals.

- Cultural taboos on premarital sexual relations: Premarital sexual activity is widely regarded as unacceptable, and societal norms strongly discourage discussions about FP or contraception among unmarried individuals.



- Stigma around contraception use: The use of contraception by unmarried individuals is seen as condoning or acknowledging premarital sexual activity, which is considered shameful. This creates a significant barrier to accessing contraception for unmarried people, even though premarital sexual activity is reportedly increasing.
- Challenges for unmarried youth: Young unmarried people engaging in sexual activity face considerable challenges in obtaining contraception due to societal disapproval and the lack of supportive systems for sexual and reproductive health services tailored to their needs.

6.2.9. Social norms on contraception and older adults:

Sexual activity in older age is widely stigmatised, leading to the view that contraception is unnecessary. Older adults thus bear a double burden as pregnancy is frowned upon, yet family planning is discouraged. Such attitudes reflect restrictive societal views on sexuality across all stages of life.

- Norms against sexual activity in older age: Sexual relations among older individuals are stigmatised, with societal expectations that they should not engage in sexual activity. This attitude extends to family planning and contraception, as these are also deemed unnecessary for this age group.
- Double burden of stigma: Older adults face a dual stigma—pregnancy is not socially acceptable, yet the use of FP methods is equally discouraged, reflecting restrictive views on sexuality across the lifespan.

6.2.10. Social norms and expectations for pregnancy after marriage:

Couples are expected to conceive within the first year of marriage, discouraging contraception use before the first pregnancy. However, once the first child is born, family planning methods are accepted and even encouraged to space births, reflecting the growing preference for smaller families.

- No contraceptive use before the first pregnancy: There is a strong societal expectation that a married couple should conceive within the first year of marriage. Using contraception before the first pregnancy is culturally discouraged. However,

conceiving too soon after marriage (within 3–4 months) is also frowned upon, as it may lead to speculation about premarital conception.

- Family planning post-first baby: After the first child, contraception use is not only accepted but expected to space subsequent births. Birth spacing aligns with the growing societal preference for smaller families.

6.2.11. Social norms around family size:

Two children are viewed as an ideal family size, with three considered acceptable. Having more than three or four children is shameful and shows a lack of knowledge, vision and planning. Families lacking a son may feel compelled to keep having children to try for a boy, reflecting a persistent son preference.

- Ideal number of children: Two children are generally considered the ideal family size, with three children still being acceptable. However, having more than three or four children is increasingly stigmatised and considered socially shameful.
- Preference for sons: In families without sons, societal pressures may lead to continued pregnancies (four or more) to try for a male child. This reflects the entrenched preference for sons in some communities.

6.2.12. Perceptions of contraception:

- Health concerns about female contraception:
Myths and Misconceptions: Misinformation about side effects or health risks discourages the use of permanent and even some temporary methods. There is a belief that using contraceptives, particularly by women, can negatively affect fertility, and health conditions deter some women from using these methods.
- Limited male involvement: Responsibility for family planning often falls disproportionately on women, perpetuating gender inequity. There is a perception that using condoms reduces sexual pleasure and an attitude that condom use diminishes a man's sense of masculinity.

6.2.13. Social stigma around permanent methods:

- Permanent family planning methods (such as sterilisation) are perceived as shameful, likely because they eliminate fertility permanently. This attitude aligns with cultural and religious values that view the loss of the ability to reproduce as discreditable. The fear of judgment or loss of societal respect prevents couples from opting for permanent family planning solutions, such as sterilisation. In rural communities, these methods are seen as irreversible and may be viewed as socially or morally unacceptable. Couples worry that choosing permanent solutions may lead to stigma, negative judgment, or a loss of status within their community, making them hesitant to make such decisions despite the benefits. This fear is rooted in deep-seated cultural and societal expectations surrounding fertility and family roles.

6.2.14. Preference for temporary methods:

- Women predominantly use oral contraceptive pills due to their availability and affordability. Condoms are less commonly used because they are perceived as costly and carry additional social stigma when purchased publicly. For birth spacing, both long-term (e.g., IUDs) and short-term methods (e.g., injectables, pills) are preferred over permanent options.

6.2.15. Regional Variations on social norms:

- Rangamati (Delaying Marriage and Pregnancy): In this region, delaying marriage is accepted, especially among the educated population who prioritise financial stability and first pregnancy after this delayed marriage is also preferred.
- Gaibandha and Bhola (Delaying for Education or Employment): Some girls in these regions delay their first pregnancy to complete education or secure jobs, but such decisions are often met with bullying or social shaming, reflecting resistance to non-traditional practices.
- Khulna (Early marriage and early pregnancy; following longer birth interval): Girls in this community tend to marry at a young age and often aim to conceive within the first year of marriage. After giving birth to their first child, they typically begin using contraception to delay subsequent pregnancies.

6.2.16. Cultural Beliefs about Family and Parenthood

Society often views a child to be owned by the family, discouraging pregnancy termination even when there are risks involved.

- Perceptions of Parenthood:
 - In some cases, societal beliefs dictate that a child is "family property" and not solely the parents' responsibility; discouraging couples from ending pregnancies even when they face significant challenges continuing this pregnancy.
 - These norms further complicate decisions around MR, especially for young and vulnerable individuals

6.3 Social norms around Menstrual Regulation

MR, a method is a common way to deal with unwanted pregnancies and is lawful under certain circumstances. MR, while legally distinct from abortion, commonly, people view it as 'abortion'. Deeply ingrained social norms and stigmas, particularly those pertaining to women's autonomy, sexuality, and reproductive choices, continue to shape and restrict MR despite its medical and legal acknowledgment. Thus MR practices face significant barriers in Bangladesh due to cultural, legal, and systemic challenges.

6.3.1. Cultural and social stigma

MR is widely seen as immoral or sinful, equated with abortion and ending a divine creation. Female sexuality is viewed primarily as reproductive, unlike male sexuality, which is also associated with pleasure. This strict link between femininity, motherhood, and caregiving makes MR especially unacceptable for unmarried or childless women. A strong emphasis on preserving sexual purity for unmarried adolescents further compounds the stigma around MR for these groups.

- Moral and Religious Perceptions: MR, often equated with abortion, is viewed as immoral, sinful, and shameful, reflecting beliefs that it kills the creation of Almighty
- Purpose of sexual intercourse: Reproduction is viewed as the only purpose for sexual intercourse for females, while, for males, it is mixed with pleasure.



- Reproduction as the only responsibility: Reproduction is perceived as the sole purpose of female sexuality and responsibility. Thus, female sexuality is strictly tied to motherhood and caregiving, making MR for unmarried or childless women especially unacceptable.
- Preference for "Sexual Purity": Social norms emphasise the preservation of sexual purity, especially for unmarried adolescents and young adults, which compounds the stigma surrounding MR for these groups compared to married women.

6.3.2. Taboos around menstruation and mr

Menstruation remains a taboo topic, fostering secrecy and shame around MR. Societal norms expect women to prioritise motherhood, making MR seem contradictory.

- Secrecy and shame: Menstruation is rarely discussed openly, creating an environment of shame and secrecy around related topics, including MR.
- Cultural expectations of motherhood: Women are expected to prioritise motherhood, and seeking MR is often viewed as contradicting this societal expectation.
- Stigma of association with abortion: Despite being a distinct procedure, MR is often conflated with abortion, which carries a strong social stigma.

6.3.3. Legal restrictions and misconceptions

- Abortion laws: Abortion is illegal in Bangladesh except when necessary to save the mother's life, while MR is legally permitted. However, confusion persists, blurring the distinction between the two.
- Unofficial requirement of service providers: Some healthcare providers impose unnecessary requirements, such as spousal consent, despite such demands being illegal according to official MR guidelines.

6.3.4. Barriers in accessing services

Health service providers often bring in their own beliefs, perceptions and judgemental attitude they grew up with and become hesitant to offer MR services. Limited training and inadequate facilities, especially in rural areas, further restrict women's access to safe MR. Lack of trust and confidentiality also set a challenge in accessing MR services.



- Healthcare provider bias: Personal biases among providers may lead to judgmental interactions or reluctance to offer MR services.
- Inadequate training and facilities: A lack of trained providers and accessible clinics, particularly in rural areas, limits women's access to safe MR.
- Confidentiality concerns: Fear and lack of privacy and confidentiality discourage women from seeking MR services in formal healthcare settings.

Societal norms surrounding MR for unmarried girls in bangladesh

- The societal expectations and norms around female sexuality and pregnancy, particularly for unmarried girls, create significant barriers to accessing safe MR services in Bangladesh. These challenges are compounded by cultural stigmas, lack of information, and structural inadequacies.

6.3.5. Stigma around premarital sexuality and pregnancy

Sexual activity outside of marriage in Bangladeshi society is heavily stigmatised, leading to severe judgment and consequences for unmarried girls. Unmarried pregnancy is considered sinful, and opting for MR is seen as intensifying that sin.

- Normative expectations: Sexual activity outside of marriage is considered immoral and unacceptable in Bangladeshi society. Unmarried girls engaging in sexual activity face severe social judgment, as it is seen as a violation of cultural and religious norms.
- Double stigma of pregnancy and MR: Unmarried pregnancy is deemed sinful, and opting for MR adds another layer of stigma, as it is perceived as compounding one sin with another.
- Giving birth outside of marriage is entirely unacceptable, leading most unmarried girls with unintended pregnancies to terminate them, often in secrecy.

6.3.6. Beliefs around MR

Unmarried girls often face limited access to safe MR services due to fear of exposure, stigma, and unsupportive healthcare settings. Stigma and shame also hinder them from seeking guidance or counselling, increasing their risk of resorting to unsafe practices.



- Lack of safe options: Unmarried girls often struggle to access safe MR services due to fear of exposure, judgment, and the lack of supportive healthcare environments.
- Limited guidance and support: Stigma and shame make it difficult for young girls to seek advice, counselling, or medical help for MR, leaving them vulnerable to unsafe practices.

6.3.7. Social norms – misconceptions about MR

Many women avoid MR due to fears it may cause infertility.

- Fertility concerns: There is a widespread belief that MR may cause future infertility, discouraging women from seeking it.
- Lack of awareness: Many people are unaware of the benefits of MR, its legal status, and its distinction from abortion, leading to confusion and hesitation.

6.3.8. Social norms and lingering stigma

Social norms discourage open discussion about MR, leading to misinformation and deterring women from seeking care, lack of privacy, resources and access—challenges that are especially acute in rural regions.

- Resistance to open discussion: Social norms discourage open conversations about MR, perpetuating misinformation and deterring women from seeking services.
- Barriers to access: Women face judgment, lack of confidentiality, and limited availability of trained providers, particularly in rural areas.

Although we observed some positive changes in the practice of MR, with some women utilizing it when necessary. However, there remains a critical need to foster an environment where women and girls are empowered to make decisions about their bodies freely. This requires addressing the interplay between societal norms, stigma, and reproductive health to eliminate fear of criticism, judgment, or violence.

6. Recommendations

A multifaceted strategy that addresses societal norms, provides accurate information, and ensures access to safe, confidential MR services is crucial to overcoming existing barriers in Bangladesh. By involving key stakeholders—communities, religious leaders, healthcare providers, legislators, and civil society organizations—Bangladesh can foster an inclusive environment that empowers women to make informed decisions about their reproductive health while challenging long-standing taboos and misconceptions.

Therefore, culturally sensitive interventions, which encourage open discourse and dismantle harmful societal norms, are therefore essential in equipping young people with the tools to make informed SRHR decisions. Here, RHRN2 Programmes can develop strategies and activities to challenge negative social norms, encourage favourable views toward CSE, FP and MR and advance gender equality and human rights by putting these ideas into practice. It is essential to work in cooperation with communities, religious leaders, government entities, civil society organisations, and other stakeholders to bring about long-lasting change in the SRHR field in Bangladesh. This research identified the following recommendations based on the findings.

6.1 Comprehensive Sexuality Education (CSE) implementation strategy

For Civil Society Organisations (CSOs):

RHRN partners can utilise their alliances to work with CSOs outside of the network to galvanise and advocate for the following:

1. Community consultation and advocacy:

- Work closely with teachers, community leaders, and religious figures to identify a culturally acceptable name for CSE that resonates with local values.
- Partner with local media outlets for advocacy campaigns to rebrand “Sexuality Education” to a term that is less controversial but retains the core educational focus.

2. Media and public awareness:

- Conduct information campaigns to gradually introduce and normalise CSE among parents and community members. These campaigns should highlight the benefits of



CSE, such as improved health, reduced early pregnancies, and overall societal well-being.

- Utilise positive news reports, TV dramas, and media discussions to showcase the impact of CSE, addressing misconceptions and stigmas while focusing on preventive health outcomes.

3. Collaboration with Community-Based Organisations (CBOs):

- Develop community-based SRHR education initiatives engaging parents, teachers, religious leaders, community leaders, and youth, ensuring their active participation.
- Educate youth about the consequences of unsafe sexual practices and promote
- Collaborate with CBOs to organise events featuring CSO members and GDC representatives to challenge stigma and promote awareness about gender diversity.

4. Government and stakeholder engagement:

- Collaborate with government bodies to ensure the implementation of culturally appropriate, age-sensitive health education programs.
- Develop a robust and tailored curriculum on SRHR, aligning it with community needs, focusing on menstrual health management and sustainable alternatives to disposable sanitary napkins.

For Government:

RHRN consortium partners having collaborations and any relationships with local government stakeholders can advocate the following:

1. Curriculum reform:

- Remove the term “Sexuality” from CSE, replacing it with a culturally acceptable alternative.
- Take a participatory approach to curriculum development, involving teachers, religious leaders, community members, and adolescents in shaping the content.
- Ensure that education on gender dynamics and power structures is included to promote shared decision-making in relationships.

2. Teacher’s training and monitoring:

- Equip teachers with appropriate vocabulary, cultural sensitivity, and communication

- Establish a monitoring system to ensure regular delivery of CSE classes.
- Develop specific, age-appropriate health education modules tailored to the emotional and cognitive maturity levels of adolescents and youth.

3. SRHR services in health facilities:

- Ensure that government health facilities offer comprehensive SRHR services, including menstrual health education through implementing accountability and monitoring mechanisms.
- Conduct training for healthcare providers at various levels to enhance their understanding of SRHR, with RHRN2 supporting training assessments and curriculum development.

For RHRN Programme:

Engage and work with the partner organisations, network partners and volunteers to take forward the following:

1. Cultural sensitivity and engagement:

- Programme designers should tailor CSE, Family Planning (FP), and Menstrual Regulation (MR) initiatives to address cultural sensitivities. Engaging parents, community leaders, and religious figures will foster greater acceptance and adoption of SRHR practices among youth.

2. Volunteer and partner training:

- Enhance the capacity of local partners and volunteers by providing training in negotiation skills, allowing them to effectively educate teachers about SRH and contraception. They should be able to guide teachers on using culturally appropriate language and approaches.
- Train volunteers to conduct awareness campaigns emphasising the benefits of CSE for preventing early pregnancy, improving menstrual health management, and promoting responsible family planning.

3. Community-based initiatives:



- Organise initiatives to promote with their network organisations and volunteers to promote CSE in classrooms, with support from parents, religious leaders, teachers, and community members.
- Engage, train and mobilise the network organisation's and volunteers to work with government bodies to ensure the delivery of age-appropriate health education programmes.
- Community-based programmes can effectively leverage trustworthy-reliable networks by training and sensitising local advisors to deliver accurate and relevant SRH information. Trusted figures can thus function as “social immunity,” protecting autonomy, facilitating confidentiality, and providing essential resources. Formalizing these roles within health and social programs could substantially improve adolescent and youth well-being.

4. Capacity building for teachers:

- Advocate for government master trainers to develop innovative teaching methods on gender diversity and SRHR topics. These approaches should be adaptable for classroom use, ensuring teachers can convey the information effectively.

By fostering collaboration between CSOs, government agencies, educators, and the community, these strategies will facilitate the acceptance and implementation of culturally sensitive CSE programmes, improving SRHR outcomes for adolescents and youth.

6.2 Family Planning (FP) implementation strategy

For Civil Society Organisations (CSOs):

RHRN partners can utilise their alliances to work with CSOs outside of the network to galvanise and advocate for the following:

1. Community engagement and peer education:

- Promote peer education by training young community members to engage with adolescents about family planning, fostering an environment where discussions on FP are normalised.
- Organise community sessions involving older female members, such as potential mothers-in-law, to educate them on the consequences of early pregnancy, and its

emotional and physical impact on young couples. These conversations should aim to reduce pressure for early childbirth.

2. Promote joint decision-making:

- Conduct separate sessions for husbands and young men, emphasising their role in shared responsibility for FP and joint decision-making within marriages, especially regarding childbearing and contraception use.
- Raise awareness about the negative consequences of societal pressures for early childbirth and gender preferences, encouraging couples to make informed decisions based on their well-being rather than external pressures.

3. Engage community influentials and religious leaders:

- Identify key community influentials, such as respected individuals in tea gardens, and provide them with accurate information on FP. Youth often seek advice from these influentials, making them crucial allies in promoting informed FP practices.
- Collaborate with religious leaders to align FP practices with religious teachings, dispelling misconceptions and promoting responsible FP behaviours within religious contexts.

For Government:

RHRN consortium partners having collaborations and any relationships with local government stakeholders can advocate the following:

1. Expand national fp programmes beyond married couples:

- Design and implement a national FP program that targets all individuals, including unmarried adolescents and youth, not just married couples, recognising the diverse needs of the population.

2. Tailor age-appropriate fp education:

- Develop age-appropriate educational content on FP, ensuring it is accessible to adolescents and youth. This should include reproductive health, contraception options, and the importance of mutual responsibility.

3. Ensure contraceptive access and non-judgmental services:



- Ensure the availability and accessibility of contraceptives for all individuals, including unmarried youth. Train service providers in non-judgmental counselling, ensuring they offer services without stigmatisation.
- Design pictorial instructions for contraceptives to ensure they are easily understood by those with limited literacy. For example, contraceptive packaging should have clear depictions of how to use condoms and what steps to take if someone misses taking a pill.

4. Monitoring and evaluation mechanisms:

- Establish monitoring and evaluation mechanisms to assess the effectiveness of FP interventions and make improvements based on evidence.

For RHRN Programme:

Engage and work with the partner organisations, network partners and volunteers to take forward the following:

1. Address gender-specific knowledge gaps:

- By engaging their network organisations and volunteers, can utilise existing information and knowledge products to address gender-specific knowledge gaps in accessing FP services. Design outreach activities for both males and females to promote shared responsibility for contraception use.

2. Educational materials and discreet distribution:

- Develop audio/visual materials, posters, and small cards with simple, easy-to-follow illustrations, instructions and information in Bengali on contraceptives, menstrual health management, SRHR, nutrition facts, and prevention of STIs/STDs. These materials should be discreet enough to be placed in books or bags and distributed widely to both males and females.

3. Encourage shared responsibility for contraception:

- Network partners and volunteers can advocate for mutual accountability in contraception use to avoid unintended pregnancies, encouraging both males and females to take responsibility for their reproductive health.

4. Collaborate with religious leaders:

- Work with religious leaders in the study sites to integrate FP education into religious contexts, promoting a better understanding of contraceptive use and its alignment with religious teachings.

5. Support FP access for unmarried youth:

- Provide FP information and services to unmarried males and females through RHRN volunteers. This is crucial in addressing the gap in FP services for unmarried adolescents and youth, especially since premarital sex is prevalent but often difficult to address through formal government channels.

6. Advocacy for improved services:

- Advocate for programmes that ensure availability and accessibility of contraceptives for all individuals, and work with related organisations to provide training for service providers on non-judgmental counselling.

7. Monitor FP programme effectiveness:

- Establish monitoring and evaluation mechanisms within the RHRN programme to assess the effectiveness of FP interventions, ensuring that they are continuously improved and adapted to community needs.

By fostering partnerships with religious leaders, community influentials, and government bodies, CSOs and RHRN can work collaboratively to ensure that FP education and services are accessible, culturally appropriate, and non-judgmental, benefiting both adolescents and the broader community.

6.3 Menstrual Regulation (MR) implementation strategy

For Civil Society Organisations (CSOs):

RHRN partners can utilise their alliances to work with CSOs outside of the network to galvanise and advocate for the following:

1. Address social stigma and cultural taboos:

- Engage community and religious leaders to address the social stigma and cultural taboos surrounding the dangers and harms caused by clandestine abortions. This can be achieved by initiating open dialogues that align MR with cultural and religious values, thereby fostering a more accepting environment for these services.

2. Promote open dialogue and education:

- Discuss the dangers and harms on women caused by secrecy, and clandestine abortions. Open dialogues on the need for females to be able to access this service and create awareness in the community to remove gossip and encourage a supportive environment.

3. Establish comprehensive support systems:

- Implement education, counselling, and access to contraceptives as part of a comprehensive support system. This will empower individuals to make informed choices about their reproductive health and manage unwanted pregnancies.

4. Foster a supportive environment:

- Cultivate a supportive environment that upholds reproductive rights and autonomy, ensuring that individuals, especially women and girls, feel respected when accessing MR services. This includes establishing safe spaces for discussions around reproductive health without judgement.

For Government:

RHRN consortium partners having collaborations and any relationships with local government stakeholders can advocate the following:

1. Capacity development for health service providers:

- Provide skills and capacity-building training for door-to-door and institution-based health-service providers, starting from tertiary levels, on offering respectful MR services. Training should emphasise a non-judgmental and caring attitude toward females seeking MR services, with particular attention to ensuring that young people receive the necessary resources.
- For monitoring and supervision, respective organisation should develop a checklist of quality of the care which may be used to make health service providers accountable to their services

2. Promote awareness through CSE:

- Incorporate education on MR and contraceptive use into Comprehensive Sexuality Education (CSE) starting in Grade 8 and focus on preventing early pregnancies and MR procedures. Young boys and girls should be made aware of contraception, MR procedures, and their rights to access these services.
- To hold awareness programme through community and institution based service facilities about their rights and responsibilities through dialogue sessions, trainings and other media

3. Encourage shared responsibility:

- Promote the shared responsibility for contraception use between males and females to avoid unintended pregnancies, fostering an environment of mutual accountability and decision-making. This can be encouraged through youth peer discussions, led by youth leaders, explaining the importance of joint efforts in preventing unplanned pregnancies.

4. Improve accessibility to quality services:

- Ensure improved accessibility to quality MRM services, FP counselling, and post-abortion care. This includes increasing the number of trained healthcare providers and ensuring they adopt non-judgmental attitudes when delivering safe and affordable MR services.

For RHRN Programme:

Engage and work with the partner organisations, network partners and volunteers to take forward the following:

1. Advocate with government agencies:

- Advocate with government agencies using evidence-based approaches to address gaps in MR services. This includes showcasing the importance of safe and accessible MR services for reproductive health.

2. Raise awareness on MR procedures:



- Promote awareness among youth, especially concerning the timing of sexual intercourse and the proper use of contraceptives to prevent unintended pregnancies, while also educating on the availability and procedures of MR services.

3. Support access to information and services:

- Advocate for service providers to ensure access to accurate information and resources on MR for individuals, FP counselling, and post-abortion care through government support. Work closely with door-to-door health service providers and those serving at health centres to revitalise their knowledge and praise their contributions to the community's health and for increased access to quality services.

By creating open dialogues, building comprehensive support systems, and ensuring accessible and non-judgmental services, these actions will help to de-stigmatize and expand the availability of MR services for women and girls, promoting informed reproductive health choices in the community.

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Annexure 1: Data collection Tools

1. Focus Group Discussion (FGD) Guideline

(Respondents: Adolescent and youth male and females)

Study title: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Each FGD will comprise 9 respondents (15-17- or 18-30-year age group) and 3 facilitators. After introducing each other, facilitators will describe the objectives of this session and the process of group discussions. At first, the facilitator will give an idea about the topics/issues that will be discussed in the FGD.

Then, three groups will be formed, and 3 respondents will be in each group. Each group will be assigned one topic to illustrate and conduct problem tree analysis. One group will do an exercise on family planning and menstrual regulation, and another on comprehensive sexuality education. Each group will be given a guideline for the group exercise. One facilitator will guide each group.

Each group will take 40 minutes to illustrate and write down the key points with marker pens on the assigned issues/topics and the sub-topics on flip paper(s).

After completing their group work, each group will present their findings, thoughts, and explanations of their identified issues in front of other FGD respondents. Others will comment, add, clarify the information, and share their thoughts.

After each group's presentation and discussion, some of the respondents of the FGD will be asked/requested to write down a short case/story/experience/practice on particular issues; an issue will be assigned to individual respondents. The respondents will write their stories/experiences and explanations of those experiences and practices on paper and submit them to the facilitators (research team). These case stories will be analysed later.

Respondents information form

Date: Programme implementation area/location:

Programme implementing organization:

Facilitator(s):

S l.	Name	Age	Education completed	Sex / gender	Ethnicity	Marital status	Received any training/session/education on SRHR (yes/no)	Involved/associated/affiliated with any organization (yes/no)	Family income

1									
2									
3									
4									
5									
6									
7									
8									
9									

FGD: Discussion points

For group 1

Issue 1: Family planning/contraceptives

What do they perceive (Attitude/Belief /value)

Knowledge and attitudes towards pregnancy, family planning, childbearing, birth spacing and contraceptive use (Probe: How do people perceive the issue of family planning? Attitude towards talking about and using family planning. When can one start taking pills? Is the family planning method applicable for boys or girls? Can unmarried people use contraception?)

What Local terms are used to express/discuss this issue?

What and how they do (Behaviour/practices)

How do they know what to use?

Who uses which method, and when?

Where do people go to get it? (Probe: Practices of using contraceptives and differences between different groups (adolescent, youth, male, females, married people, unmarried people)



Why they do (Norms/factors/social rule)

How do the people of society view "appropriate behaviour" for using or discussing family planning/contraception? Which should not be done? Who thinks it is, and why? If someone does not behave "appropriately", how does society view them?

How and why do they choose what to take? Who makes the decision to use it? What shapes the choices, decision-making process, and ability to purchase contraceptives, opt for family planning and pregnancy?

Why do they not use it?

What are the (health and social) outcomes of these practices?

Who enforces (Reference group)

Who are the influencers of this choice and decision-making process? (Probe: How do other people influence the decision, preference and expectations of family planning, reproduction, and contraception use.)

Identify some practices mentioned above that you would like to change and how?

What can be done to change individual and group (negative, harmful) attitudes and behaviours and how?

For group 2

Issue 2: Menstrual Regulation (MR)

What do they perceive (Attitude/Belief /value)

What do people think about menstruation regulation? (Probe: How do people perceive it? Attitude towards performing MR)

What Local terms are used to express/discuss this issue?

What and how they do (Behavior/practices)

What do people (Married-Unmarried Girls) practice for MR? When, from whom, and from whom do they receive information and services? (Probe: Practices of using MR and differences between different groups (adolescent, youth, married and unmarried female)

Why they do (Norms/factors/social rule/reasons)

Why do they use MR? Why do they not use MR? How are the MR-related choices and decisions made?

How do these impact behaviour and practices? What are the outcomes of these practices?

What are the societal views towards "appropriate behaviour" for menstrual regulation? Which should be done or not be done? Who thinks it, say, why think? Who are the other people, and how do they expect it? If someone does not behave "appropriately", how does society view them?

Who enforces (Reference group)

Who are the influencers of these choices and decision-making processes? (Probe: How these influencers influence the preference and expectations of MR use.)

Identify some practices mentioned above which you would like to change and how?

What can be done to change individual and group (negative, harmful) attitudes and behaviour towards menstrual regulation?

For group 3

Issue 3: Comprehensive Sexuality Education

What do they perceive (Attitude/Belief /value)

What are the myths/taboo/beliefs around comprehensive sexuality education (CSE)

What do people think about the necessity of CSE? (Probe: How do people perceive it? Attitude towards receiving and providing CSE; what happens if one learns about sexuality and SRHR-how people perceive it?)

What Local terms are used to express/discuss this issue?

What and how they do (Behaviour/practices)

What are the common practices of receiving and providing CSE?

(probe: whom to ask regarding SRHR and sexuality-related information; what age is appropriate to learn about these issues?)

Why they do (Norms/factors/social rules)

What are the "appropriate behaviours" in the eyes of society in receiving and providing CSE? Which should not be done? Who thinks it, and why? If someone does not behave "appropriately", how does society view them?

What are the barriers and challenges to receiving CSE? What is an ideal and supportive environment for receiving CSE (at schools, in awareness sessions or training)?

How do these impact CSE information dissemination? Is there any change in attitude or practice after receiving CSE?

Who enforces (Reference group)

Who and how do others perceive receiving CSE? Who are the influencers expected to provide information or knowledge regarding sexuality and SRHR if CSE is not taught in schools?

Identify some practices mentioned above which you would like to change and how?

Do you think CSE is necessary? If so, what can be done? Who

are the pressure groups that may be involved? Whose consent is necessary and why?

What can be done to change individual and group (negative, harmful) attitudes and behaviours towards promoting CSE?

Case story write-up by respondents

After completing the problem tree analysis session, each respondent will be asked to write down their experiences of any case/story related to the abovementioned issues. For example, they will express their experiences about receiving information on and practices related to Family planning, menstruation regulation, and comprehensive sexuality education. They will also add their observation/analysis of their story's factors or underlying reasons.

They will be provided with paper and a pen to write it down within the next 20 minutes. All write-ups will be collected. Here, facilitators also guide them on how to write their cases.

Probable topics

- Access to family planning information, services, methods, problems and barriers.
- Access to information and services about menstrual regularization, any events, problems and obstacles that have made menstrual regularization.
- Experiences, problems and barriers to learning about comprehensive sexuality education.

2. IDI Guidelines

(For adolescents and youth)

Issue 1: Comprehensive Sexual Education

1. What do you know about CSE? What is your opinion about the importance of comprehensive sexuality education (CSE) for individuals of all ages?
2. Could you describe the typical practices within your community regarding taking or providing CSE? Whom do you usually go to for information related to SRHR and sexuality? (Probe: What are the available information and education sources on CSE? Who can provide information and education, and who can receive information?)
3. What barriers and challenges do you face in accessing comprehensive sexuality education? What are your community's prevailing myths, taboos, or beliefs regarding comprehensive sexuality education (CSE)? How do you and your community feel about receiving and providing CSE information? (please use FGD findings, how those social norms influence his/her behaviour and practices and community practices.)
4. How do reference groups influence the perception and reception of CSE within your community?
5. What do you recommend to do or change negative/harmful attitudes and behaviours towards the misbeliefs and practices regarding CSE in your community?

Issue 2: Family Planning

6. What do you know about family planning?
7. What is your attitude to and beliefs on family planning method use? Probe: Is it necessary to know the information? Why? Where do you usually get information from?)
8. (If you use), what methods of contraception do you use? How did you get it? (Probe: When do you use those methods (or not)? How do you choose and decide?)
9. What are the societal views as "appropriate behaviour" on discussing and using family planning methods/contraception? Who can use and discuss, and who does not? Which should not be done? What are the underlying factors behind the decision-making process? (please use FGD findings, how those social norms influence his/her behaviour and practices; What do you think are the main reasons why some individuals in your community use or do

not use or talk about contraceptives, and what effects do these decisions have on their health and social lives?)

10. Who are the influencers of this choice and decision-making process? (Probe: How do other people influence the decision, preference, and expectations of family planning, reproduction, and contraception use.)

11. What do you recommend to change negative/harmful attitudes and behaviours towards the misbeliefs, superstitions, taboos and practices regarding family planning in your own community?

Issue 3: Menstrual Regulation (MR)

12. Do you know about menstruation regulation? (Probe: When is it necessary to use? Who can use it, and who does not use it? What do community people think-who can use and who does not: Adolescents, youth, married women, and unmarried women in your community)

13. (For girls) Have you ever used MR services? Why, from where? What were the barriers and challenges?

14. What are the practices in your community commonly used for Menstrual Regulation (MR)? From whom and where do they receive the information and services? (please use FGD findings, how those social norms influence his/her and community people's attitudes and practices.)

15. Who are the influencers of these choices and decision-making processes? How do they influence?

16. What do you recommend to change negative/harmful attitudes and behaviours towards the misbeliefs, superstitions, taboos and practices regarding MR in your own community?

3. Key-informant interview guidelines

(Respondents: Local people, parents, youth leaders, teachers, program people)

Issue 1: Comprehensive sexuality education (CSE)

What people perceive (attitudes/beliefs/values)

What are the attitudes of community/community people towards comprehensive sexuality education? What do they believe? What is this idea based on?

What are the behaviours/practices of CSE, and how do community people, especially teenagers and youth in the community

What are the common practices in comprehensive reproductive and sexuality education?

Where do adolescents and young adults usually get information and education from? What do they do? Who decides on these practices?

Does this habit/practice have any effect on their lives?

Why do they do it (norms/reasons/social norms)

What behaviour is considered normal and acceptable in the community? What are the social expectations regarding this behaviour?



Why do people do that (particular) exercise/practice? What happens to choice, decision making and consent? How and why?

If someone behaves outside of normal and approved practices, how do others regard it (social approval)?

What can be done for positive changes?

Do you think there needs to be any change in their behaviour/practice/information sharing regarding comprehensive reproductive and sexuality education? Which ones need to be changed?

How can these changes be made by involving whom?

Topic 2: Family planning

What do people perceive (attitudes/beliefs/values) about family planning?

What are the attitudes of people in the community/community towards family planning?

What do they believe?

What are these thoughts or beliefs based on?

What do and how people in the community behave/practice, especially teenagers and youth in the community

Who do or can they (adolescents and youth-community people) discuss family planning? Where do adolescents and young adults receive information and education about family planning (schools, public-private organizations)? What are the opportunities and barriers to getting this information?

What are the practices among them? What are the practices among married and unmarried adolescents and young males and females?

Does this habit/practice have any effect on their health or life?

Why do they do it (norms/reasons/social norms)

What behaviour is considered acceptable in the community? What are the social expectations regarding this behaviour?

Where are the opportunities or barriers to discussing family planning? Who interrupts?

Why do people do that (particular) exercise/practice? Who makes their choices, consents, and decisions, how and why?

If someone behaves outside of normal and approved practices, how do other people view it (how is social approval)?

What can be done for positive changes?

What do you think needs to be changed in their behaviour/behaviours/information sharing?

How can these changes be made by involving whom?

Topic 3: Menstrual Regulation

What people perceive (attitudes/beliefs/values)

What are the attitudes of community people towards menstrual regulation?



What do they believe?

What are these thoughts or beliefs based on?

What do and how do people in the community behave/practice, especially teenagers and youth in the community

Who do or can they (adolescents and youth, people in the community) discuss menstrual regulation? Where do adolescents and young adults receive information and education about menstrual regulation (schools, public-private organizations)? What are the opportunities and barriers to getting this information?

What are the practices among them? What are the practices among teenagers young women (married or unmarried)?

Does this habit/practice have any effect on their health or life?

Why do they do it (norms/reasons/social norms)

What behaviour is considered socially acceptable for menstrual regulation? What are the social expectations regarding this behaviour?

Where are the opportunities or barriers to performing menstrual regulation? Who interrupts?

Why do people do (special) practices/practices regarding menstrual regulation? Who makes their choices, consents, and decisions, how and why?

If someone behaves outside of normal and approved practices, how do other people view it (how is social approval)?

What can be done for positive changes?

What do you think needs to be changed in their behaviour/behaviours/information sharing regarding menstrual regulation?

How can these changes be made by involving whom?

Annexure 2: Information sheet and consent form

1. Informed consent form for FGD/IDI respondents (Youth)

Information Sheet

Project name: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Introduction: Greetings. My name is/ (we are) and I am a member/ (we are members) of the research team of BRAC James P Grant School of Public Health, BRAC University. We are currently conducting a study on “Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh”. This study is being implemented in collaboration with Naripokkho and Right Here Right Now 2 (RHRN 2) programme in Bangladesh.

Serial no.: IRB-27 September'23-033

Aim: Adolescence and youth are the very promising period of life for all. However, Sexual and Reproductive Health and Rights (SRHR) issues of adolescents and young male and female including gender diverse population remain unaddressed due to conservative societal set-up and stereotypical gender norms and taboos.

Their practice and understanding of sexual relationships, family planning, consent and choice, menstrual regulation, menstrual health management and access to comprehensive sexuality education are heavily influenced by existing social norms. Therefore, this study aims to understand the social norms around SRHR and the underlying reasons for these social norms. The findings of this study will inform about norm-shifting strategies to reach RHRN2 programme objectives.

Justification of participation:

You're the valued member of these groups (youth, age >18), and target beneficiaries involved in RHRN programme implementation. You are well known and aware of the issue, we will discuss in this session. Therefore, your perception, knowledge, experiences, opinion and suggestions will be beneficial to us for the study. Your provided information will help to understand the situation and give an insight to inform about norm-shifting strategies for the RHRN2 programme.

Procedure:

If you agree to participate, you will be asked to take part in a focus group discussion (FGD) and share a case story in written form or In-depth Interview (IDI). The FGD will last approximately 120-150 minutes and writing case story will take approximately 20 minutes. The IDI will last approximately 60-80 minutes. If you allow, the discussion/interview session will be audio-recorded to ensure accurate capture of the information you provide. The audio recordings will be transcribed and anonymized for analysis. The data collected will be treated with strict confidentiality and used solely for research purposes.

After the focus group discussion, some of you will be asked to write down a case story on paper about your experience or knowledge or observation of a particular topic, the reasons behind this experience or event, to share with us. The stories submitted by you will be analyzed anonymously. The information you provide will be treated with strict confidentiality and will be used for research purposes only.

Benefits of participation: You will not be given any sort of financial assistance for participating in this study, and nor will you get any other direct facilities or compensation. But based on the information obtained from this study will support understanding which will also help to inform programmes to take innovative strategies for implementing programme activities that can benefit people like you.

Risk: You don't have any risk of being physically or mentally harmed if you participate in this study. We may ask you some sensitive questions, which may make you a bit uncomfortable. However, if you wish not to answer any such sensitive or personal question, please let us know, and we will respect your decision. We will try to finish the discussion without further embarrassing you.

Confidentiality and anonymity: This interview/data collection process will not hamper or influence you anyhow. All information about the respondents of this interview or case story will be kept secret and anonymous and will only be used for research purposes. Research respondent identification information will be coded (re-named) by using numbers and alphabets. Your personal information (including name, address, etc.) is for identification purposes only and will not be shared with other parties and will be handled very carefully so that your privacy won't be violated.

We want to inform you that, during the interview, we will take some photographs of you and record the interviews with your permission.

All data will be stored in a separate file in computer and digital space that can only be viewed by core authorized researchers.

Your name and other confidential and identifiable information will never be mentioned in any publication or reports rather de-identified (such as, pseudonym) information will be used. However, for audit purposes, if needed, the Institutional Review Board (IRB) of BRAC JPGSPH may access research records.

Nature of participation: Participating in this research is completely optional, dependent upon your own will and voluntarily. You have all the right to know the research process, risks, and facilities of this study. Even if you agree to participate but later change your decision, you can stop the interview at any time and withdraw yourself from the study within 10 days. Whatever decision you make, that will not create any problems for you.

Contact information: If you have any queries regarding this research, please contact-

Subas Biswas (Senior Research Fellow, BRAC James P Grant School of Public Health, BRAC University), T: +880-2-48812213-18; M: +8801711336739)

Contact Information of Institutional Review Board: IRB Administrator, BRAC James P. Grant School of Public Health, BRAC University; Phone - + 801993379512. Email: irb-jpgsph@bracu.ac.bd

Consent Form

Title of the study: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Details of the Respondents:

If you agree to participate in this study, please confirm by putting your signature/thumbprint.

Thank you for your cordial cooperation.

(Note to investigator: Please note that the items below can vary from protocol to protocol)

Do you give permission for the interview/discussion to be audio recorded? Yes No
[Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.] o

Do you give permission to share your findings? Yes No
o

Do you give permission to take photos? Yes No
o

Do you give permission to share the photos? Yes No
(If you need to contact the/collect data from the respondent again, need to state here and ask permission...) o

Do you have any questions? Yes No
o

State the question

Interviewer name: Respondent's name:

Interviewer signature: Respondent's signature/thumbprint:

Date: Date:

2. Informed assent form for FGD/IDI respondents (<18)

Information Sheet

Project name: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Introduction: Greetings. My name is/ (we are) and I am a member/ (we are members) of the research team of BRAC James P Grant School of Public Health, BRAC University. We are currently conducting a study on “Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh”. This study is being implemented in collaboration with Naripokkho and Right Here Right Now 2 (RHRN 2) programme in Bangladesh.

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Their practice and understanding of sexual relationships, family planning, consent and choice, menstrual regulation, menstrual health management and access to comprehensive sexuality education are heavily influenced by existing social norms. Therefore, this study aims to understand the social norms around SRHR and the underlying reasons for these social norms. The findings of this study will inform about norm-shifting strategies to reach RHRN2 programme objectives.

Justification of participation:

As you're a valued member of these groups (adolescent male or female), who are well known and aware of the issue, your perception, knowledge, experiences, opinion and suggestions will be beneficial to us for the study. Your provided information will help to understand the situation and give an insight to inform about norm-shifting strategies for the RHRN2 programme.

As you are under the age of 18, we have obtained permission and consent from your guardian/parents for your participation. Now we are seeking your assent.

Procedure:

If you agree to participate, you will be asked to take part in a focus group discussion (FGD) and share a case story in written form or In-depth Interview (IDI). The FGD will last approximately 120-150 minutes and writing case story will take approximately 20 minutes. The IDI will last approximately 60-80 minutes. If you allow, the discussion/interview session will be audio-recorded to ensure accurate capture of the information you provide. The audio recordings will be transcribed and anonymized for analysis. The data collected will be treated with strict confidentiality and used solely for research purposes.

After the focus group discussion, some of you will be asked to write down a story on paper describing your experience or knowledge or observation of a particular topic, the reasons behind this experience or event, to share with us. The cases/stories submitted by you will be analyzed anonymously. The information you provide will be treated with strict confidentiality and will be used for research purposes only.

Benefits of participation: You will not be given any sort of financial assistance for participating in this study, and nor will you get any other direct facilities or compensation. But based on the information obtained from this study will support understanding which will also help to inform programmes to take innovative strategies for implementing programme activities that can benefit people like you.

Risk: You don't have any risk of being physically or mentally harmed if you participate in this study. We may ask you some sensitive questions, which may make you a bit uncomfortable. However, if you wish not to answer any such sensitive or personal question, please let us know, and we will respect your decision. We will try to finish the discussion without further embarrassing you.

Confidentiality and anonymity: This interview/data collection process will not hamper or influence you anyhow. All information about the respondents of this interview will be kept secret and anonymous and will only be used for research purposes. Research respondent identification information will be coded (re-named) by using numbers and alphabets. Your personal information (including name, address, etc.) is for identification purposes only and will not be shared with other parties and will be handled very carefully so that your privacy won't be violated.

We want to inform you that, during the interview, we will take some photographs of you and record the interviews with your permission. All data will be stored in a separate file in computer and digital space that can only be viewed by core authorized researchers.

Your name and other confidential and identifiable information will never be mentioned in any publication or reports rather de-identified (such as, pseudonym) information will be used. However, for audit purposes, if needed, the Institutional Review Board (IRB) of BRAC JPGSPH may access research records.

Nature of participation: Participating in this research is completely optional, dependent upon your own will and voluntarily. You have all the right to know the research process, risks, and facilities of this study. Even if you agree to participate but later change your decision, you can stop the interview at any time and withdraw yourself from the study within 10 days. Whatever decision you make, that will not create any problems for you.

Contact information: If you have any queries regarding this research, please contact-

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Contact Information of Institutional Review Board: IRB Administrator, BRAC James P. Grant School of Public Health, BRAC University; Phone - + 801993379512. Email: irb-jpgsph@bracu.ac.bd

Consent Form

Title of the study: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Details of the Respondents:

If you agree to participate in this study, please confirm by putting your signature/thumbprint.

Thank you for your cordial cooperation.

(Note to investigator: Please note that the items below can vary from protocol to protocol)

Do you give permission for the interview/discussion to be audio recorded? Yes No
[Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.] o

Do you give permission to share your findings? Yes No
o

Do you give permission to take photos? Yes No
o

Do you give permission to share the photos? Yes No
(If you need to contact the/collect data from the respondent o
again, need to state here and ask permission...)

Do you have any questions? Yes No
o

State the question

Interviewer name: Respondent's name:

Interviewer signature: Respondent's signature/thumbprint:

Date: Date:

3. Informed consent form for Key Informant Interview (KII) respondents

Information Sheet for the community influential people/parent/teacher/youth leader/programme people

Project name: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Introduction: Greetings. My name is/ (we are) and I am a member/ (we are members) of the research team of BRAC James P Grant School of Public Health, BRAC University. We are currently conducting a study on “Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh”. This study is being implemented in collaboration with Naripokkho and Right Here Right Now 2 (RHRN 2) programme in Bangladesh.

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Their practice and understanding of sexual relationships, family planning, consent and choice, menstrual regulation, menstrual health management and access to comprehensive sexuality education are heavily influenced by existing social norms. Therefore, this study aims to understand the social norms around SRHR and the underlying reasons for these social norms. The findings of this study will inform about norm-shifting strategies to reach RHRN2 programme objectives.

Justification of participation:

You're an important/influential people of this community, or parent of adolescent and youth, teacher, or youth leader or key stakeholder involved in RHRN programme implementation who are well known and aware of the issue. Your perception, knowledge, experiences, opinion and suggestions will be beneficial to us for the study. Your provided information will help to understand the situation and give an insight to inform about norm-shifting strategies for the RHRN2 programme.

Procedure:

If you (community influential people/parent/teacher/youth leader/programme people) agree to participate, you will be asked to take part in a Key Informant Interview (KII). The KII session will last approximately 60-80 minutes. If you allow, the discussion/interview session will be

audio-recorded to ensure accurate capture of the information you provide. The audio recordings will be transcribed and anonymized for analysis. The data collected will be treated with strict confidentiality and used solely for research purposes.

Benefits of participation: You will not be given any sort of financial assistance for participating in this study, and nor will you get any other direct facilities or compensation. But based on the information obtained from this study will support understanding which will also help to inform programmes to take innovative strategies for implementing programme activities that can benefit people like you.

Risk: You don't have any risk of being physically or mentally harmed if you participate in this study. If we have any questions, which you may feel uncomfortable, you wish not to answer any such sensitive or personal question, please let us know, and we will respect your decision.

Confidentiality and anonymity: This interview/data collection process will not hamper or influence you anyhow. All information about the respondents of this interview will be kept secret and anonymous and will only be used for research purposes. Research respondent identification information will be coded (re-named) by using numbers and alphabets. Your personal information (including name, address, etc.) is for identification purposes only and will not be shared with other parties and will be handled very carefully so that your privacy won't be violated.

We want to inform you that, during the interview, we will take some photographs of you and record the interviews with your permission. All data will be stored in a separate file in computer and digital space that can only be viewed by core authorized researchers.

Your name and other confidential and identifiable information will never be mentioned in any publication or reports rather de-identified (such as, pseudonym) information will be used. However, for audit purposes, if needed, the Institutional Review Board (IRB) of BRAC JPGSPH may access research records.

Nature of participation: Participating in this research is completely optional, dependent upon your own will and voluntarily. You have all the right to know the research process, risks, and facilities of this study. Even if you agree to participate but later change your decision, you can stop the interview at any time and withdraw yourself from the study within 10 days. Whatever decision you make, that will not create any problems for you.

Contact information: If you have any queries regarding this research, please contact-

Subas Biswas (Senior Research Fellow, BRAC James P Grant School of Public Health, BRAC University), T: +880-2-48812213-18; M: +8801711336739)

Contact Information of Institutional Review Board: IRB Administrator, BRAC James P. Grant School of Public Health, BRAC University; Phone - + 801993379512. Email: irb-jpgsph@bracu.ac.bd

Consent Form

Title of the study: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Details of the Respondents:

If you agree to participate in this study, please confirm by putting your signature/thumbprint.

Thank you for your cordial cooperation.

(Note to investigator: Please note that the items below can vary from protocol to protocol)

Do you give permission for the interview/discussion to be audio recorded? Yes No
[Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.] o

Do you give permission to share your findings? Yes No
o

Do you give permission to take photos? Yes No
o

Do you give permission to share the photos? Yes No
(If you need to contact the/collect data from the respondent again, need to state here and ask permission...) o

Do you have any questions? Yes No
o

State the question

Interviewer name: Respondent's name:

Interviewer signature: Respondent's signature/thumbprint:

Date: Date:

4. Informed consent form for parent/guardians to allow their children to participate as respondents

Information Sheet

Project name: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Introduction: Greetings. My name is/ (we are) and I am a member/ (we are members) of the research team of BRAC James P Grant School of Public Health, BRAC University. We are currently conducting a study on “Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh”. This study is being implemented in collaboration with Naripokkho and Right Here Right Now 2 (RHRN 2) programme in Bangladesh.

Serial no.: IRB-27 September'23-033

Aim: Adolescence and youth are the very promising period of life for all. However, Sexual and Reproductive Health and Rights (SRHR) issues of adolescents and young male and female including gender diverse population remain unaddressed due to conservative societal set-up and stereotypical gender norms and taboos.

Their practice and understanding of sexual relationships, family planning, consent and choice, menstrual regulation, menstrual health management and access to comprehensive sexuality education are heavily influenced by existing social norms. Therefore, this study aims to understand the social norms around SRHR and the underlying reasons for these social norms. The findings of this study will inform about norm-shifting strategies to reach RHRN2 programme objectives.

Justification of participation:

Your child is a valued member of these groups (adolescent, age <18), who have experiences and are aware of the issue, their perception, knowledge, experiences, opinion and suggestions will be beneficial to us for the study. Their provided information will help to understand the situation and give an insight to inform about norm-shifting strategies for the RHRN2 programme.

As you are the parent/guardian of the minors (adolescent, age <18 years), your permission and consent for recruiting the adolescents (your children/relatives) is important. We will also take assent from those minor respondents for the participation in this research after receiving your consent.

Procedure:

If you agree and allow them (adolescents) to participate, they will be asked to take part in a focused group discussion (FGD) and/or write a short case story or In-depth Interview (IDI). The FDG will last approximately 120-150 minutes, writing case story will take approximately 20 minutes and IDI will be around 60-80 minutes. If you allow, the FGD/IDI session will be audio-recorded to ensure accurate capture of the information they provide. The audio

recordings will be transcribed and anonymized for analysis all of the information, they will provide. The data collected will be treated with strict confidentiality and used solely for research purposes.

Benefits of participation: You or your child will not be given any sort of financial assistance for allowing and participating in this study respectively, and nor will you or your child get any other direct facilities or compensation. But based on the information obtained from this study will support understanding which will also help to inform programmes to take innovative strategies for implementing programme activities that can benefit people like adolescent and youth.

Risk: Your child does not have any risk of being physically or mentally harmed if they participate in this study. We will ask them some questions, if they wish not to answer any question, we will respect their decision.

Confidentiality and anonymity: This interview/data collection process will not hamper or influence them anyhow. All information about the respondents of this interview will be kept secret and anonymous and will only be used for research purposes. Research respondent identification information will be coded (re-named) by using numbers and alphabets. Respondent's personal information (including name, address, etc.) is for identification purposes only and will not be shared with other parties and will be handled very carefully so that their privacy won't be violated.

We want to inform you that, during the interview, we will take some photographs of them and record the interviews with your and their permission. All data will be stored in a separate file in computer and digital space that can only be viewed by core authorized researchers.

Their name and other confidential and identifiable information will never be mentioned in any publication or reports rather de-identified (such as, pseudonym) information will be used. However, for audit purposes, if needed, the Institutional Review Board (IRB) of BRAC JPGSPH may access research records.

Nature of participation: Participating of your child in this research is completely optional, dependent upon your own will and voluntarily. You have all the right to know the research process, risks, and facilities of this study. Even if you agree to let your child to participate but later change your decision, you can stop the interview at any time and withdraw your child's participation from the study within 10 days. Whatever decision you make, that will not create any problems for you.

Contact information: If you have any queries regarding this research, please contact-

Subas Biswas (Senior Research Fellow, BRAC James P Grant School of Public Health, BRAC University), T: +880-2-48812213-18; M: +8801711336739)

Contact Information of Institutional Review Board: IRB Administrator, BRAC James P. Grant School of Public Health, BRAC University; Phone - + 801993379512. Email: irb-jpgsph@bracu.ac.bd

Consent Form

Title of the study: Understanding Social Norms related to adolescent and youth Sexual and Reproductive Health and Rights (SRHR) in Bangladesh

Details of the Respondents:

If you agree to let your child to participate in this study, please confirm by putting your signature/thumbprint.

Thank you for your cordial cooperation.

(Note to investigator: Please note that the items below can vary from protocol to protocol)

Do you give permission to let participate your child for the interview/discussion to be audio recorded? [Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.]

Yes No
o

Do you give permission to share findings?

Yes No
o

Do you give permission to take photos?

Yes No
o

Do you give permission to share the photos?

Yes No
o

(If you need to contact the/collect data from the respondent again, need to state here and ask permission...)

Do you have any questions?

Yes No
o

State the question

Interviewer name: Respondent's name:

Interviewer signature: Respondent's signature/thumbprint:

Date: Date: