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How the Adolescents Applied their Learning in their Lives: An Evaluation of the Adolescent Development Programme of BRAC

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Abstract

This paper aims to measure the changes in the type and depth of knowledge and understanding on sexual and reproductive health and gender issues, and how they obtained that knowledge. Secondly, changes in the ways in which adolescents were practically applying this understanding, or intended to apply it in their own lives (or not) were determined; if not, then reasons for not doing so were determined. Both qualitative and quantitative methods were employed in this research. Results show that knowledge on sexual reproductive health and gender discrimination changed positively and participants had been able to apply increased knowledge in their own lives, in the lives of their families and in their communities, by changing their parents' and influential persons' embedded attitudes. On the other hand, there were some who did not apply the knowledge in practice because of failing to overcome the entrenched norms, attitudes and beliefs that are deeply ingrained in the family and community. In conclusion we suggest that the intervention should continue with additional measures to ensure the involvement of the community, so that the limitations could be removed for a sustainable change.

I. Introduction

Statement of the problem

In 2001, according to the Bangladesh Bureau of Statistics (BBS), adolescents (aged 10-19 years) accounted for around one-third of the total population of Bangladesh. Recently BBS (2008) mentions that adolescents (aged 11-19)[1] are one-fifth of the total population while Sood and Shuib (2011) mentions that 28 million adolescents constitute 22% of the population of whom 13.8 million are female. They have the potential to become 'human capital' and contribute positively towards development. However, in developing countries like Bangladesh, they are also one of the most vulnerable groups. In these countries, for only a privileged group, the period of adolescence is marked by sound health and stable family conditions. Nevertheless, it can also be a period of vulnerabilities because of intense and rapid transitions to new roles and responsibilities as caretakers, workers, spouses, or even parents (Chong *et al.* 2006).

Given a socio-cultural environment of pervasive gender discrimination, girls are treated differently from birth, resulting in inequalities of nutrition, health, education and financial status (Sood 2011). The conservative culture of Bangladesh puts emphasis on the strict chastity of women which is perhaps a potential threat to adolescents in terms of their complete social and psychological development. With the advent of puberty, differences in the ways that adolescent girls are treated become much more restrictive, specifically with regard to restriction of mobility of adolescent girls, which in turn limits their access to livelihood and experiential learning (Amin *et al.* 2002).

Another persistent problem in rural areas in Bangladesh is the lack of sufficient and/or well-paying employment opportunities for girls. This lack of opportunity coincides with the cultural tradition of confining young girls/women within the home and teaching them to play passive roles in decision making, both inside and outside the family context. This also marks the end of many girls' formal education, as they are expected to devote their full time to domestic chores in their husband's household (Ambrus and Field 2008). Besides, girls' families are under social pressure for daughters to marry early, before the adolescent's sexual maturity may be seen to invite assault, harassment or abuse, which would tarnish the family honour (Sood 2011).

The Bangladesh Demographic Health Survey (BDHS 2007) report indicates that almost half of the women aged between 20 and 49 years got married before their 15th birthday, that 27% of the brides aged 17 years old very soon become mothers and 7% were pregnant with the first child. This means that a significant portion of

[1] BRAC defines as adolescents those aged between 11 and 19 years for its Adolescent Development Programme.

adolescents aged 15-19 become mothers of one or more children with little knowledge of reproductive health. In other words, knowledge of adolescents on reproductive health is very low, and they lack information about changes associated with puberty, sexuality, contraception and sexually transmitted infections (STI) (Nahar *et al.* 1999; Barkat and Majid 2003).

The adolescent fertility rate in Bangladeh is one of the highest in the world with 135 births per 1,000 women aged <20 years, which is five times higher than that of Sri Lanka (MOHFW 1999; NIPORT, Mitra and Associates and Macro International 2005). A recent study on 237 students of a private university in Dhaka shows that these youngsters have little knowledge of and no access to sexual and reproductive health information (Yugi 2006), which leads them to suffer a greater burden of ill health than the rest of the population, particularly during pregnancy and child birth. Given the background of a lack of knowledge about sexual and reproductive health, and gender discrimination in decision making in family and society, adolescents, particularly girls, can hardly make meaningful career choices.

Overview of the adolescent development programme in BRAC

It is important to learn more about timing, nature, and consequences of the key transitions towards adulthood, and in particular how these play out amongst the most vulnerable groups and design strategies to provide adolescent girls and boys with a safe, healthy, and productive transition to the responsibilities of adulthood. Most developed countries prioritize keeping their adolescents involved in capacity building activities, the main instrument for which is education. Unfortunately, there are many adolescents in developing countries who are not in school and therefore, may be at higher risk for negative outcomes (Rahman and Sulaiman 2006).

In order to address their vulnerabilities BRAC started the Adolescent Development Programme (ADP) in 1993, arising from BRAC's school programme for older children. In order to retain the literacy, numeracy and life skills that many girls lost after primary schooling, BRAC's Education Programme (BEP) opened the Adolescent Clubs giving girls the chance to socialize, play indoor games, sing, dance and exchange views and experiences - all activities that were frowned upon in their homes. The programme works with the Ministry of Women and Children's Affairs (MOWCA) and Department of Youth Development under the Ministry of Youth and Sports of the government of Bangladesh.

The activities of the ADP are given below:

a. Adolescent Clubs (*Kishori Kendro*) are the safe places where adolescent girls can read, socialize, play games, take part in cultural activities and have open discussion on personal and social issues with their peers. Each club consists of 25-35 teenage members aged 10-19 years. One adolescent leader is responsible for the operation of a club. At present there are 8,100 adolescent clubs in Bangladesh. Activities include exchanging books, reading newspapers and magazines, playing

indoor and outdoor games, performing cultural programmes and observing different international and national days.

b. Adolescent Peer Organized Network (APON) offers adolescents life-skill based education - facilitated by their peers - on different social and health-related issues, such as reproductive health, sexual abuse, children's rights, gender, HIV/AIDS, STI, eve teasing (verbal sexual abuse), child trafficking, substance abuse, violence, family planning, child marriage, dowry, and acid throwing. The purpose is to develop adolescent life skills and raise awareness of important but stigmatized issues. These courses are offered in adolescent clubs, secondary schools, madrasas and working places.

c. Livelihood training courses are offered to girls to empower them financially. Adolescents receive training on tailoring, embroidery, journalism, poultry, livestock and beauty care, etc. (in collaboration with the Ministry of Youth and Sport and other local organizations). These training courses are organized in 307 *upazilas* of 57 districts.

Special Network for Adolescent Photographers (SNAP) is a network of adolescent female photographers who received training on digital photography. The adolescents take photography as a profession. By this occupation they not only overcome their financial hardships but are also able to highlight different adolescent-related issues. The girls take photos relevant to social issues and organize exhibitions to raise awareness within their communities.

d. Communication, awareness and advocacy works through interaction and dialogue among adolescents, their parents and influential persons in the community. Different types of forum with mothers, parents and community leaders create the foundation for a supportive communication network. This formalized communication network helps ensure that the ideas of adolescents are heard, as well as promote community attitudes supporting adolescent development. Community members in rural areas often have very little idea about children's rights, importance of girls' education and many other adolescent issues. Therefore, it is essential to bring whole communities under one roof to make them aware of adolescent issues.

ADP communications, awareness and advocacy have taken the following initiatives:

Interactive popular theatre (IPT) plays a strong role to disseminate and initiate dialogue among the community. Therefore, ADP established APON interactive theatre groups in 2005 across the country with adolescent members. Each group performs IPT shows on different social issues to create awareness in the community.

Adolescent fairs have also been introduced in 2008 as a part of ADP's different awareness activities. These fairs create a space solely for the adolescents and establish adolescents' identity as a distinct group in the population. This occasion also brings out their potential in front of the wider community. The whole fair is

organized with different products made by adolescent club members such as handicrafts, nursery items, local and tribal goods, etc. Essay writing and painting competitions for students, cultural programmes, sports, theatre, and rallies are organized as part of this event. Through these fairs ADP tries to involve people from every sphere of the community to create awareness on different adolescent-related issues.

Cultural competition is an initiative to make the community aware of the importance of cultural activities for their cognitive development. This brings out adolescents' talent through cultural competition and provides required training to increase their capacity in cultural performance. This competition started from adolescent clubs followed by cluster adolescent clubs, *upazila* and district level competitions. The final competition takes part at the national level and top contestants participate in a competition which is telecast on satellite TV channels. This initiative received positive responses from the community and plays a significant role in adolescents' cultural development.

Sports for development is a new initiative which includes two activities. One is outdoor sports and the other is safe swimming. Outdoor sports initiative involves adolescent girls to increase girls' participation in outdoor sports and creating awareness of different issues among people through different sporting events. ADP provided formal training by national coaches to form football, cricket and volleyball teams and organized regular practice sessions for adolescent girls. This initiative received positive response from the community and from the National Sports Federation.

Safe swimming is another initiative which aims to reduce child death from drowning by engaging adolescents as swimming instructors. ADP started this initiative from July 2009 in collaboration with Centre for Injury Prevention and Research, Bangladesh (CIPRB) and Bangladesh Swimming Federation. The technical support is given by CIPRB and the Bangladesh Swimming Federation. Older adolescents (18+) from the ADP programme are selected as community swimming instructors and are trained by Bangladesh Swimming Federation to teach swimming lessons to children aged 4 to 10 years in their communities. Through this programme the people not only learn about the scientific way of swimming but also realize the importance of knowing how to swim.

This study aims to find out the knowledge level of beneficiaries on reproductive health and gender and to understand the practical applications by beneficiaries (i.e. the implications for their lives) as an outcome of sexual and reproductive health and rights (SRHR) and gender education provided by ADP. Specifically the study focuses on:

- The type and depth of knowledge and understanding beneficiaries have of SRHR and gender issues, and how they obtained this knowledge and understanding.

- Ways in which they are practically applying this understanding, or intend to apply it, in their own lives (or not); if not then reasons for not doing so.

Rationale of the study

There were many studies done by the Research and Evaluation Division (RED) of BRAC on various aspects of adolescents and the adolescent programme. These were reviewed to identify gaps that needed further research.

Mahbub *et al.* (2007) prepared a report to assess the impact of the ADP programme, which shows that 77% of ADP boys and girls had knowledge about only AIDS, (but not STD, or HIV). After the intervention, a majority had gained knowledge on contraceptive (57.5%), suitable marital age and effects of early marriage (98%), and health deterioration (82%). Only 7% had knowledge on the risks involved in childbirth.

Embedded perception was observed in the study with regard to the importance of female work in the household and their contribution to the household economy, but a majority (around 80%) had changed perception, saying that both boys and girls should be given equal importance in their education. Also an entrenched attitude towards the work of married girls outside the home was found. But an overwhelming number of respondents (77%) mentioned that they had been able to take decisions on education-related issues. Sixty-seven percent of the boys consulted with their friends on reproductive issues while 43% of the girls shared information with parents on the same issues. Health-seeking behaviour of adolescents was also explored, and it was found that 20% of them did not take any medical treatment.

Jinnat and Narayan (2010) found a positive impact of the BRAC ADP programme in terms of overall awareness among the participants and their parents. But on many issues like legal age of marriage and subsequent marriage, the level of awareness remained low. On the other hand, there was a positive impact from the intervention in changing parents' attitude towards gender, but the extent of change was very small. With regard to reproductive health only physical changes and the effects of it on mental health, and awareness of HIV/AIDS (keep safe from HIV, ways in which person can/cannot become HIV positive), and attitudes towards gender equality were measured. But the reasons for change (or not) were not addressed.

Anindita and Narayan's recent study (2011) on the profile of adolescents for the Social and Financial Empowerment of Adolescents (SoFEA) programme of BRAC measured the level of awareness on health, social and legal issues, financial literacy, perception of marriage, gender roles, overall status in personal and family settings, as well as parents' perceptions of the girls concerning these issues. No practice related to the issues as mentioned except girls' mobility was addressed in this study.

Gani and Masud (2006), through an adolescent survey in 2005, focused on physical, mental and sexual changes of adolescents, their marriage, family planning, pregnancy and care. This study gave lot more emphasis to reproductive health issues. A majority (95%) of the adolescents reported knowledge on any family

planning method but a limited number (17%) used any modern method. Besides, a majority of them (both male and female) reported knowledge on pregnancy-related complications for which a doctor's help is required. Around one-fifth of them knew other important complications.

Rahman and Sulaiman (2006) only focused on descriptive statistics using the same data that Gani and Masud used to see socio-demographic factors, labour market participation and aspiration of adolescents. Among socio-demographic information the age of leaving school was almost the same for rural and urban females at about age 15. Rural female adolescents were 9% less likely to be involved in employment than the urban adolescents. Married females were 24% less likely to be employed.

Regarding aspirations, 48% reported that they wanted to be like themselves. Besides, Muslim girls were less likely to participate in paid work and more likely to engage in household work only, while there was no significant influence of religion on boy's working decisions. Over 80% of the out-of-school adolescent girls in urban areas were primarily engaged in household work only but the corresponding figure in rural areas was 93%.

The studies mentioned above provided some different social and health dimensions of adolescent girls, but did not concentrate on the depth of their cognitive level and practices in their lives, or on qualitative changes due to intervention in these dimensions. Therefore, this study endeavoured to fill this gap, which was yet to be explored.

Theoretical discussion

To improve the quality of life of adolescents, especially girls BRAC provides knowledge on essential issues and skills for earning through establishing clubs with the help of the community. The programme mainly aims to empower adolescents, that they would not only be knowledgeable about key issues, but also take important decisions in every sphere of life. Through the ADP programme BRAC strives to change embedded perceptions and practices regarding adolescents. The question is how much BRAC succeeds in enabling adolescents to be active in their lives in the face of entrenched social attitudes and practices. To understand this, we need to look at the existing situation of girls/women within the purview of the male-dominated family – one of the most important institutions in the society.

There are many institutions in the society that are patriarchal in nature. The family, religion, and the law are the pillars of a patriarchal system and structure. This well-knit and deep-rooted system makes patriarchy seem invincible; it also makes it seem natural.

The family, the basic unit of society, is probably the most patriarchal, meaning male dominated. A man is considered the head of the household; within the family he controls women's sexuality, labour or production, reproduction and mobility. It is within the family that adolescents learn the first lessons in hierarchy, subordination,

and discrimination. Boys learn to assert and dominate, girls to submit, to expect unequal treatment. Although the extent and nature of male control may differ in different families, it is never absent. The family plays an important role in creating a hierarchical system and keeping order in society. It not only mirrors the order in the state and educates its children to follow it. It also creates and constantly reinforces that order (Lerner 1986).

Women are obliged to provide sexual services to their men according to their needs and desires. A whole moral and legal regime exists to restrict the expression of women's sexuality outside marriage in every society, whereas customarily, a blind eye is turned towards male promiscuity. Rape and the threat of rape is another way in which women's sexuality is dominated through an invocation of 'shame' and 'honour'. In order to control women's sexuality, dress, behaviour and mobility are carefully monitored by familial, social, cultural and religious codes of behaviour.

Men control women's productivity both within the household and outside, in paid work. Within the household women provide all kinds of free service to their children, husbands and other members of the family, throughout their lives. In what Walby (1990) call the 'patriarchal mode of production', women's labour is expropriated by their husbands and others who live there. Their back-breaking, endless and repetitive labour is not considered work at all and housewives are seen to be dependent on their husbands.

Men also control women's reproductive power. In many societies women do not have the freedom to decide how many children they want, when to have them, whether they can use contraception, or terminate a pregnancy, etc. In modern times, the patriarchal state tries to control women's reproduction through family planning programmes. The state decides the optimum size of the country's population and accordingly, actively encourages or discourages women to have children.

The ideology of motherhood subjugates women because the burden of mothering and nurturing is forced on to them, and only on them, by patriarchal societies. Motherhood is forced by depriving young women of adequate contraceptive information; the contraceptives it does make available are inconvenient, unreliable, expensive and often dangerous. Patriarchal belief limits abortions and often seeks to deny them entirely, but at the same time subjects women to intense and unremitting pressure to engage in sexual relations (Jagger 1993).

In order to control women's sexuality, production and reproduction, men need to control women's mobility. The imposition of *parda* (veil), restrictions on leaving the domestic space, a strict separation of private and public, limits on interaction between the sexes, and so on, all control women's mobility and freedom in ways that are unique to them – that is, they are gender-specific, because men are not subjected to the same constraints.

Most property and other productive resources are controlled by men and they pass from one man to another, usually from father to son. Even where women have the

legal right to inherit such assets, a whole array of customary practices, emotional pressures, social sanctions and, sometimes, plain violence, prevent them from acquiring actual control over them.

All major religions have been interpreted, and controlled by upper class and upper caste men; they defined morality, ethics, behaviour and even law; they have laid down the duties and rights of men and women, the relationship between them. There is sufficient analysis to show how almost every religion considers women to be inferior, impure, sinful; how they have created double standards of morality and behaviour; how religious laws often justify the use of violence against 'deviant' women; how iniquitous relationships are sanctioned and legitimized by recourse to 'religious' creeds and fundamental tenets.

Laws pertaining to family, marriage and inheritance are very closely linked to the patriarchal control over property. In South Asia every legal system considers a man the head of the household, the natural guardian of children and the primary inheritor of property.

II. Methods

This study extracted data from primary sources that was collected from the field, and secondary sources that included a UNICEF report[2]. The first was cross-sectional and included areas where the programme was carried out and those where it was not. As mentioned earlier under objectives, the study focused on two themes and several issues under the themes (Matrix 1). Secondly, out of many issues in the UNICEF report, reproductive health and gender were considered in this study.

The study area was purposively selected because of time and budget constraints as well as the nature of objective of the study. Besides, it was necessary to take into account the availability of accommodation for the researcher, and better communication to ADP clubs for organizing group discussions easily, especially with girls who were not in the clubs. Thus, two area offices in Mymensingh district were selected.

[2] UNICEF had a programme that aimed to increase knowledge, improve attitudes and enable behaviour change connected to early marriage, dowry, marriage registration, birth registration, child rights and HIV/AIDS, implemented by Bangladesh Ministry of Women and Children's Affairs and several local and international PNGOs (Partner Non-Governmental Organizations) including BRAC, CMES, Bangladesh Shishu Academy and Save the Children, Australia.

A research team consisting of different implementers and donors conducted baseline and endline surveys from which a report was prepared on the basis of the issues mentioned above, and included treatment and control areas.

The evaluation design for the quantitative component of the *Kishori Abhijan* project by UNICEF made use of two stage random sampling techniques to assess baseline outcomes in 27 districts comprising Centre for Mass Education in Science (CMES) intervention and matched control sites, BRAC girls' programme intervention and matched control sites, and the Bangladesh Shishu Academy sites which were selected from among the BSA intervention sites with 128 secondary schools in 64 districts.

The sampling strategy for the quantitative component of the endline was exactly the same as the baseline. Since the BRAC intervention design changed mid-stream and the importance of including boys in the intervention was highlighted, therefore, the baseline design was modified for BRAC sites to include 1 Peer Leader (PL) and 3 adolescent boys along with 10 adolescent girls from each site. The number of adolescent boys and girls were the same in control sites as well. During the data collection, efforts were made to trace the original baseline adolescent and peer leader respondents in both the intervention and control sites. This created the scope to examine what happened in the control sites in the absence of an intervention.

Separate tools were designed in English and extensively pre-tested in Bangla for adolescents (including PL), parents, and Community Influential (CI). The questionnaires were designed to determine what knowledge, attitudes and behaviour existed around key outcomes, reproductive health and related outcomes, interpersonal communication and social networks, life skills and related outcomes, as well as knowledge, attitudes, and actions connected to the *Kishori Abhijan* intervention. Two rounds of field training preceded data collection administered by 89 field staff. Verbal informed consent was sought, confidentiality ensured, and the survey methods supervised by a survey manager and four quality control officers.

A total of 8,634 respondents were selected for the sample: 287 PL, 4,517 adolescents, 1,378 mothers, 1,341 fathers, and 1,398 community influential persons. Non-response rates were 0.79% overall. However, the sample sizes were kept similar to the baseline, which included 46 PL, 240 adolescents and 48 teachers.

Matrix 1. Themes and issues considered in this study

Themes	Issues
Knowledge on sexual and reproductive health	• Personal health and hygiene (girls), knowing physical changes • Menstruation/wet dream • Cycle of reproductive health (how a baby is born) • Contraceptive methods • Consequences of early marriage, suitable age of child bearing age • Pregnancy (Antenatal and postnatal care) • Spread/not spread of HIV/AIDS • Sign and symptom of STD • Health-seeking behaviour • Marriage and birth registration
Gender discrimination	• Conception of gender • Experience of discrimination in education, work, health, food intake • Decision making on any issues of reproductive health • Decision on desired number of children and sex • Decision making on household assets and marriage, education • Mobility • Experience of violence • Sexual harassment • Dowry

Sample size, tools and technique

Firstly, the sample size, tools and techniques used by UNICEF study were mentioned earlier. Secondly, for qualitative study the clubs that were in BRAC primary schools were randomly selected from an area office. There were numbers of well, average and badly performing clubs. Among those clubs a good club and a bad (relatively inactive) club from each area office were randomly selected. The clubs which are running smoothly for a long time and where the presence of participants is better, where participants share their knowledge with parents and friends, and turn their life skill training into reality, meaning that they become self-employed, are called good clubs. The opposite of those good clubs was treated as bad clubs. There were some clubs which performed somewhat better than bad clubs and these were called average performing clubs. Thus, four clubs were selected in the ADP areas - two were good and the other two were bad.

On the other hand, the non-ADP areas were selected from nearby villages where there was no ADP intervention. As there was no ADP club in the non-ADP areas so the interview was conducted with the adolescent girls by forming a group and

maintaining similar characteristics to ADP areas. The same numbers of groups from this area were selected for discussion and interview.

Focus group discussion (FGD) and key informant interview (KII) were the main tools and techniques for data collection. According to the sample size as mentioned, 4 FGDs with adolescent girls in ADP areas and 4 from non-ADP areas were conducted. In addition, 4 key informant interviews were carried out consecutively with a girl who was a peer leader[3] of the club, the mother of the girl, and a boy from an ADP club. Finally, a member of the 'village elite' who was actively involved with the club was interviewed.

FGDs were exclusively held with adolescent girls. The study selected ADP clubs which were 2 years old, i.e., clubs were formed in January, 2008 and continued up to December 2009.

A well planned and detailed checklist was made to collect data. The checklist focused on the issues mentioned in Table 1. According to the objectives, issues are divided into two groups: sex and reproductive health and gender relations. Data were tape-recorded and notes were taken at the same time during the implementation of FGD and in depth interview.

Detailed information on how the knowledge on the themes and issues was provided to the adolescents by the programmes was collected. In addition thorough understanding of the adolescents' programme based on the issues was also collected.

Depth of knowledge on each issue was defined such that adolescents must have complete, not partial, knowledge on the issue as mentioned. On the other hand, implementation of the knowledge in adolescents' lives was addressed through small examples and cases. For unmarried girls, the implementation of the knowledge they acquired about some issues was considered to be taking place when they shared with friends, parents, neighbours and relatives. Besides, information on how the knowledge was applied and the problems faced while applying the understanding was also collected using '5Ws and 1H', meaning: what, whom, where, when, how, and why. Reasons for applying and not applying the knowledge and understanding in their lives were examined. Data from adolescents was triangulated with influential persons (school teacher, elected Union *Parishad* member or village elite) and parents, including information on their own knowledge and the uses of that knowledge in their lives.

[3] The leader was selected on the bases of her willingness and capacity to lead and to manage the club efficiently. Besides, she was also responsible for delivering knowledge on different issues that affect the lives of the members, after training was received from the BRAC learning centre. The duration of the training was a week. After the training she provided two days of training to the participants of the club every week. The leader received Tk 25 per lecture. The content of the training was mainly related to reproductive health, antenatal and postnatal care of pregnant mother and gender relations. The leader trained the participants especially about the APON course. The participants were advised to share their learning with their parents, friends, relatives and neighbours. Refreshers courses were also conducted.

Data analysis

Quantitative data were analyzed by UNICEF and qualitative data from this study were transcribed and complied. Data were categorized based on themes and issues, and after a rigorous reading the data were sorted and the repeated information was discarded. The report was prepared by comparing the knowledge level and its nature of application including the rationalization of success and failure of practical application of knowledge in their lives in both adolescents from ADP areas and non-ADP areas.

The rationalization of success and failure by the adolescents in making use of the new knowledge in their lives was explained within the framework of theoretical discussion.

III. Findings

This section describes the knowledge level of respondents on reproductive health and related issues, family planning, child marriage, pregnancy and ante/postnatal care, HIV/STI, marriage and birth registration on the one hand, and gender norms, attitudes, gender discrimination, sexual harassment, dowry and violence against women on the other hand. Comparison of the knowledge and practices between ADP and non-ADP areas was also done. All quantitative findings in this report were taken from the UNICEF study.

Knowledge on reproductive health and other issues, and gender and gender discrimination were explored. The respondents' knowledge on the issues as mentioned in the Matrix 1 between ADP and non-ADP was compared using qualitative data. The results show that there were three types of knowledge found both in the ADP and non-ADP areas: 1) complete knowledge, 2) fairly knowledgeable, and 3) did not have knowledge. Complete knowledge means the knowledge of the respondents who understood the issue in-depth. For example, definition of 'discrimination' was any kind of discriminatory behaviour against a girl or woman.

Knowledge of the respondents on reproductive health and other issues

This section includes the level of knowledge of the respondents on reproductive health, personal health and hygiene, family planning, early marriage, pregnancy and pre and postnatal care, HIV/AIDs and STD, and finally birth and marriage registration.

Reproductive health

Reproductive health addresses the reproductive processes, functions and system at all stages of life. The respondents were asked to explain what the term 'reproductive health' meant to them.

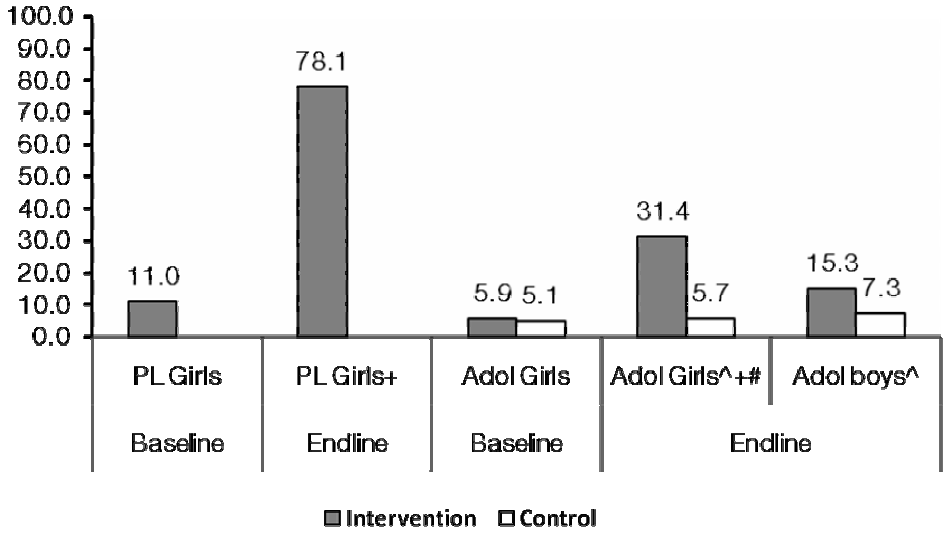
The respondents were aware of what types of issues reproductive health comprises (i.e. the human reproductive anatomy, the changes that occur in puberty, how human reproduction functions, etc.) (Fig. 1). The only significant differences were among adolescent girls and boys. More adolescent boys, girls and mothers in ADP areas reported of having such knowledge than those in non-ADPareas. There were no other changes in knowledge of reproductive health noted.

However, the in-depth interviews reveal that adolescent girls from ADP areas had complete knowledge on reproductive health. To them reproductive health is unknown but when they were asked what the *boyosondhikal* (puberty) is they could answer correctly, meaning that they had complete knowledge. All ADP girls stated, *"The*

condition of the organ of body is used for giving birth of a baby is called reproductive health." They also mentioned the age range of 10-19 years as *boyosondhikal.* On the other hand, girls from non-ADP areas did not have any knowledge regarding reproductive health or *boyosondhikal*.

Adolescent boys from ADP and non-ADP areas also did not know what reproductive health is. Rather they have wrong perceptions. A respondent mentioned, *"Adaptation of health from one environment to another environment is called reproductive health."* Other respondent stated, *"The parts of the body which are used for reproduction is called reproductive health."* Similar findings were provided by influential people in the village from both ADP and non-ADP areas. The reason for not knowing it as stated by both the groups is that they did not learn it anywhere and nobody gave them any training. A boy stated, *"As I study in the Madrasa where only Arabic is studied instead of Bangla I have not heard of this term." Others mentioned, "I was informed what this was but I have forgotten."*

Figure 1. Proportion of respondents who were aware of reproductive health



Note: PL refers to Peer Leaders. Adol refers to adolescents. CI refers to community influentials. ^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq. + indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

Health and hygiene

Adolescent girls from ADP areas were aware of personal health and hygiene. In other words, they understood menstruation and related matters as personal health and hygiene. More clearly, the adolescent girls understood cleanliness during menstruation. Before joining ADP clubs these girls had lot of misconceptions and misperceptions and malpractices with regard to menstruation. One of them mentioned, *"When I was not familiar with it there was a problem. In my case, when menstruation emerged for the first time then I had no idea about this. Parents and grandmother advised me not to eat egg, milk and fish during menstruation because that would create a bad smell. My cleanliness process was not hygienic. I used a cloth but did not clean the cloth properly and did not use hot water for cleaning the cloth. Then I had many problems. But when I became a member of the club then I knew more about it and also become more aware of the issue."*

In addition, girls were aware of the side effects of not maintaining hygienic conditions. They had been able to nullify the malpractices related to menstruation that their mother and grandmother or neighbours advised them to practice. One of them mentioned, *"The first time when menstruation started I was not aware of it. There were some problems like urine infection, itching, etc. When I knew that I remained clean during the menstruation period and realized that my guardian did not have the right information, that blood goes out from the body and these shortages have to be compensated for, then the other members of my family didn't say anything against these ideas. Now I can live safely."*

Another girl told, *"It happened the second time during my menstruation cycle. My mother cooked eggs but didn't give me to eat. I told my mother, why are you not giving me the egg? Mother replied that I should not eat eggs at this time as it might create problem forme. Then I told my mother that this was not right; the blood that goes out from my body creates a shortage for me. If I do not eat nutritious food, how can this deficiency be fulfilled? Then my mother did not say anything."*

Adolescent boys from ADP areas reported to be aware about personal health and hygiene. They were also aware of wet-dreams and what should be done if it takes place. A boy mentioned, *"Awareness of personal health and hygiene was expressed by a boy who got up early in the morning and washed hand and mouth and if he experienced wet-dream he took bath in the morning and clean up."* On the other hand, non-ADP boys had little knowledge about personal health and hygiene. Besides, the physical and biological changes that are taking place during the adolescent period were successfully reported by all types of respondents from ADP and non-ADP areas.

The adolescent boys in the ADP areas were well informed about wet-dreams and the reason for them and also the remedy for this, but few from non-ADP areas reported to have any in-depth knowledge. A boy from ADP area stated, *"The wet-dream is a natural matter for an adolescent boy; nobody should get afraid of this. Rather he should stay clean during this time; this is not a disease. Nobody should go to doctor*

for treatment; many seek to go to the Kabiraj (untrained physician) because of their ignorance." On the other hand, a boy from a non-ADP area stated, *"I do not know what the wet-dream is and what should I do then. I assume that there will be a physical problem due to wet-dream and I feel disturbed."* On the other hand, influential people from both ADP and non-ADP areas had in-depth knowledge about wet-dreams and mentioned that this should be treated as a normal matter for adolescent boys. In this case they should not be worried too much or seek a doctor. However, some of them had a bad perception of wet-dreams. One said, *"When wet-dream takes place, the young boy should be given less food that weakens him physically and finally hinders wet-dream."* Village influential people's knowledge on this matter was acquired from ADP meetings, whereas in non-ADP areas they learned from their personal experience.

Family planning

Adolescent girls from ADP areas had complete knowledge about family planning and the methods with regard to it. Some of the adolescents from non-ADP areas had complete knowledge on family planning and others did not. A boy who had knowledge stated, *"Family planning is the way through which a family is to be kept smaller and organized beautifully. Besides, 'to keep a family smaller in size is called family planning' was stated by adolescent boys from ADP areas."* Others stated, *"It's a method to control birth. It has permanent and temporary methods."* On the other hand, adolescents from non-ADP areas were also found knowledgeable about it. All influential village people in the ADP areas had in-depth knowledge on family planning. One stated, *"Family planning means running a family with a plan and keep it smaller."* In non-ADP areas influential village people had a fairly good knowledge about family planning.

Adolescent boys and girls from ADP areas had complete knowledge of family planning methods. One of them mentioned, *"There are two types of family planning method: permanent and temporary. The permanent method includes ligation and vasectomy, while pill and condom are temporary."* The adolescents from non-ADP areas did not know about family planning methods.

Regarding family planning methods influential villagers and the mothers of girls in ADP clubs in ADP areas had complete knowledge. One of them mentioned, *"When a family is run with a plan there will be fewer babies. Vasectomy, ligation, and injection are among the family planning methods. I myself did not adopt any method but my wife takes pill and also injection."* Influential village people from non-ADP areas also had clear ideas about family planning methods. One of them stated, *"There are various types of family planning methods like taking pill, using condom, and also there is abstention from sexual intercourse."*

Early marriage

Survey reveals that all adolescents from ADP areas had better knowledge of early marriage compared to non-ADP areas (Table 1). Only 39% of adolescent girls in non-

ADP areas reported that marriage before 18/21 years was 'early marriage', compared to 84.8% of adolescent girls in intervention sites. At the same time mothers, fathers and CI in the intervention sites also showed better knowledge levels of early marriage than those in the control areas.

The findings show that adolescent girls from ADP areas had appropriate knowledge about early marriage. They knew about the legal age of marriage and the demerits of it. One of them stated, *"The legal age of marriage for female is 18 years and for male 21 years. If someone get married below these ages, it is called early marriage. There are no advantages of early marriage, only disadvantages. If early marriage takes places it creates many problems such as disrupting education, social and psychological pressure, threat to the lives of both baby and mother due to early pregnancy, etc."*

Similarly, adolescent boys in ADP areas defined early marriage properly. One of them stated, *"Generally marriage before 18 for girls and below 21 for boys is called early marriage".* On the other hand, boys from non-ADP areas also had complete knowledge of this but most of them did not know the demerits of early marriage. Some of them mentioned advantages of early marriage. Many of them stated, *"To get girls or boys married off at an earlier age, or when they themselves arrange to get married, is called early marriage."* In other words, basically if there is a marriage of a girl between 12 to 13 years of age, then only this is called early marriage. Many of the adolescent boys from the same area were fairly knowledgeable about early marriage. Influential village people from non-ADP areas had partial knowledge of early marriage.

Very few of the influential village people from ADP areas had partial knowledge of the legal age of marriage. One of them mentioned, *"To get boys/girls married before their legal age of marriage is called early marriage, but I cannot remember the specified ages for marriage."* On the other hand, all influential village people from non-ADP areas had profound knowledge on early marriage and its demerits.

Table 1. Knowledge of the respondents on early marriage

Early marriage	Adolescent					
	Baseline		Endline			
	Girls		Girls		Boys	
	I	C	I	C	I	C
Marriage before proper age	39.6	40.3	21.6	42.4	20.7	31.6
Marriage before adulthood	18.8	19.0	9.4	11.6	9.2	11.5
Marriage before 18/21	44.0	38.1	84.8^+	38.9	76.6^	42.0
Don't know	9.9	14.0	1.8	12.7	3.8	12.8
N	1080	1078	961	960	261	288

Note: C refers to Control group and I to intervention group. CI refers to community influentials.

^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq. + indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq.

What is pregnancy?

The adolescent girls from ADP areas generally had complete knowledge about pregnancy, while a few of them did not have any idea because of not encountering this incidence in their own lives.

ADP boys and influential village people from ADP areas were completely knowledgeable about pregnancy. One of the boys mentioned, *"When husband and wife have a sexual relationship the suckranu (spermatozoid) and dimbanu (ovum) unites together in the zygote and baby gradually becomes bigger in the womb; this is called pregnancy."* Their source of knowledge was ADP books and meetings. On the other hand, non-ADP boys showed partial knowledge on this issue. For example, a non-ADP boy stated, *"Animals and other creatures can become pregnant. When an animal or human being comes to the earth through a sexual relationship, before coming to the world the place where they stay is pregnancy."* Their knowledge was just from their experience in life and knowledge gained from society and books. Influential people from ADP areas had clear knowledge about pregnancy.

Pre and postnatal care and danger sign for pregnant mothers

Both ADP girls and boys had complete knowledge of prenatal care for pregnant mothers. One of them mentioned, *"Pregnant mothers should not do heavy work. They should eat nutritious food, take rest, and have regular check-up."* On the other hand, some of the boys and girls from non-ADP areas had fairly good knowledge of antenatal care but others did not. What one boy knew included, *"Before giving birth pregnant mothers should not do such work that creates any pressure on their bellies. The food that should be given to them must contain vitamins."* Boys were also aware of the type of preparation a pregnant mother should take when she is about to give birth. A boy from ADP stated, *"During the period closer to delivery, other family members especially husbands from rural areas should make arrangements for a knife, blade, midwife, and rickshaw van to avoid any kind of complications for the pregnant mother."* Both ADP and non-ADP influential people were knowledgeable about the issue discussed, based on their life experience. But when they were asked about this issue, then they replied that they did not know. One said, *"When my wife was pregnant doctors advised me to take her care."*

As with antenatal care, knowledge on postnatal care for mothers was found to be complete among the ADP boys and girls. One of them stated, *"The mother should be taken care of after giving birth to a baby, as was done during her pregnancy."* Non-ADP boys did not have knowledge about postnatal care.

Knowledge about danger signs for pregnant mothers was reported complete among both ADP boys and girls. One of them mentioned, *"There are some danger signs for pregnant mothers such as convulsion, severe headache, delayed delivery, and excessive bleeding." Some of the boys from non-ADP areas had complete knowledge on the danger symptoms of pregnant mothers and some of them were partially aware of this topic.* One of them mentioned, *"There are six or seven danger*

symptoms for pregnant mothers, I cannot remember exactly, for example, headache during delivery leg comes out instead of head."

STI and HIV/AIDS awareness

The proportion of respondents who were aware of HIV and STIs was determined by the UNICEF study. Ninety-five percent of the peer leaders in both ADP and non-ADP areas reportedly heard about HIV/AIDS. At the other extreme, only four out of ten mothers both in ADP and non-ADP areas reportedly heard of HIV/AIDS. All peer leaders knew about HIV, and on the other end 48% of the mothers in control sites knew about HIV.

Peer leaders' knowledge of STI moved from 8.8 to 51% after the intervention. Similarly, adolescent girls in intervention sites also displayed significant increase in their knowledge on STIs over time. At baseline 1.9% of girls reported to know about STIs, and the corresponding figures for endline are 18.7%. Similarly, mothers' knowledge also shows change with 3.9% of intervention mothers at baseline reporting they knew about STIs compared to 8.1% of intervention mothers at endline. There were no significant changes reported in fathers' and 'community influentials' knowledge over time, with their knowledge showing a decline from 25.9 and 48.0% percent respectively at baseline to 16.7 and 30.5% at endline.

Besides, the depth of knowledge on the issues mentioned was found to be different in the in-depth study. ADP girls had complete knowledge of HIV/AIDs and awareness of STI. One of them stated, *"STI disease affects the sexual organ of the body, through diseases such as syphilis, gonorrhea, etc."* Knowledge of HIV among the ADP boys was also found to be complete. A boy stated, *"HIV is a virus which reduces the power of prevention from disease and ultimately the sufferers die."* The boys also had knowledge of this virus and how it spreads. A boy stated, *"Sexual intercourse without condoms, and using same syringes/needles to take blood are ways of spreading HIV."* However, most of the boys did not have idea on STI/STD. Those who knew about it mentioned it as follows, *"The diseases found in sex organs are sexually transmitted diseases. For example, gonorrhea and syphilis, spread through sexual activities. Because of intercourse this happens and cancer spreads through sex."* On the other hand, few non-ADP boys and girls had complete knowledge of HIV/AIDS; some had partial knowledge, but they did not have any knowledge about STDs.

All 'village influentials' in ADP areas knew the name of HIV but had partial knowledge of how this disease spreads. 'Village influentials' from non-ADP areas were fairly knowledgeable about STI and how it spreads, but did not know the causes of the spread of STI.

Birth and marriage registration

Table 2 shows that in intervention sites at endline only 1% of PL reported that they did not know what birth registration is, whereas the corresponding proportion from

the baseline was 25.6%. Similar declines in lack of knowledge were visible among other respondents as well. For example among mothers in intervention sites some 74.5% at baseline indicated they did not know about birth registration, and this proportion dropped to 18.1% in endline. Among the 'community influentials', the respondents in intervention sites reporting they did not know reduced from 23.7 to 2.9%. Specific responses to where births are registered, i.e. Union *Parishad* Office and Pourvasha Office increased significantly across all respondent types in intervention sites between baseline and endline. It is important to note that the gains in knowledge about birth registration are apparent in the control sites as well, for all respondents.

The respondents were asked to explain marriage registration and why marriage is registered. There were a few significant changes in the knowledge of marriage registration between baseline and endline for PL and adolescent girl. On the positive side, the key difference between control and intervention sites among adolescents was that in intervention sites the number of adolescents reporting they did not know what marriage registration was dropped from 44.3 to 19.1%. It appears that in control sites, there was a smaller group of respondents who knew about marriage registration and had the correct information about its details. The others did not know what it was and were hence unaware of details as well. In addition, knowledge about the details of marriage registration was more varied and in-depth in the intervention sites.

Findings from in-depth analysis show that ADP girls were aware about birth and marriage registration and also know what would have happened without the registration. ADP boys had complete knowledge on birth registration and they also reported the disadvantages of being without registration. One of them mentioned, *"If there is no birth registration she/he cannot get admission into school, can't know his/her own age, and will face difficulties to get a job."* Non-ADP boys and girls were aware of birth registration but ignorant about marriage registration; however, they were also aware of the necessity of birth registration.

Concerning birth and marriage registration 'village influentials' had complete knowledge and they also knew the merits and demerits of birth and marriage registration; in non-ADP areas also, this group had complete knowledge on both birth and marriage registration.

Table 2. Frequency of responses regarding birth registration

Indicator	PL		Adolescent					
	Baseline	Endline	Baseline		Endline			
	Girls	Girls	Girls	Girls	Girls		Boys	
	I only	I only	I	C	I	C	I	C
What is birth registration?								
Registering child after birth	17.7	37.5+	7.9	8.0#	22.1^+	10.8	14.9	11.8
Registering child's name/address	29.8	70.8+	16.9	16.4#	60.4^+	52.4	44.1	46.2
Registering child's date of birth	28.4	42.7+	16.7	14.5#	38.2^+	29.5	41.4	35.1
Don't know	25.6	1.0	53.7	56.8	5.9	19.4	9.2	14.6
Where are births registered?								
Union *Parishad* office	29.6	89.6+	12.3	12.2#	80.1^+	65.3	75.5	71.9
Pourashava Office	16.7	37.5+	5.6	5.5#	17.8^+	8.0	19.5^	8.3
Immunization Centre	20.4	4.2	15.0	12.7	2.5	2.7	0.8	1.4
Health Centre/worker	17.6	7.3	15.5	12.2	2.8	2.5	1.1	1.4
Hospital (after birth)	9.3	2.1	5.6	5.9	1.0	0.9	0.8	1.0
School/school teacher	6.9	2.1	3.1	3.2	2.4	3.5	3.1	3.1
Don't know	31.0	1.0	58.4	61.8	8.5	24.3	14.6	18.8
Why are births registered?								
To inform local government	5.6	5.3	1.5	1.9#	1.0^	0.2	1.5	1.7
To ensure citizenship	14.8	63.5+	6.6	7.1#	27.1^+	14.1	33.3	27.4
Listed for immunization	12.0	7.4	9.7	5.7	3.6	2.4	0.8	1.0
To keep document of proper age	36.6	34.4	19.2	20.1	27.5^+	20.4	44.4	39.6
To admit child in school	53.7	93.8	31.4	27.4	84.8	68.2	69.7	62.2
Needed to get a job	44.9	87.5	20.3	17.4	76.0	55.1	64.4	58.7
Don't know	25.9	1.0	54.9	58.0	6.0	20.8	10.0	15.3
N	216	96	1080	1078	961	960	261	288

Note: C refers to Control group and I to intervention group. CI refers to community influentials. ^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq. + indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

Knowledge of gender and its related issues

This section includes knowledge of respondents both from ADP and non-ADP areas on gender, decisions on household assets and family planning, domestic violence, sexual harassment, dowry, and girls' mobility.

Definition of gender and gender discrimination

The question 'what is gender' was asked to adolescent boys and girls from ADP areas and the results show that some of them were knowledgeable about gender. A girl mentioned, *"Gender is something that defines the roles of men and women in society - it is a social proposition"* while a boy mentioned, *"What is created from somaj (society) and people from somaj can change is gender."*

All of them had complete knowledge on gender discrimination (except health discrimination). One said, *"If priority is given to boy in any case, for instance education, compared to a girl, this should be treated as discrimination."* Gender discrimination has many faces as mentioned earlier. Those who had complete knowledge on this issue came to know about it from different sources but mainly from ADP clubs. Different elements of gender discrimination in education, nutrition intake, and division of labour were known to them. An ADP girl mentioned, *"When father or brother becomes sick they should be more taken care of.*" In addition, as males make the family prosper they are given more and nutritious food. An adolescent mentioned, *"Giving more priority to son than daughter is gender discrimination*." He further explained, *"When a son is given more food compared to a daughter, this is nutrition-related discrimination, and where boys are supposed to work in the field and daughters work at home, this is thought of as work-related discrimination."* With regard to compulsory education all respondents in ADP areas knew very well that both boys and girls should be educated at least up to class five.

Some of the boys from the ADP areas defined gender discrimination incorrectly and described the masculine and feminine characteristics of a male and female. One stated, *"Males will speak loudly, and work in the field and will order females and female will carry out the order of males."* Discrimination in nutrition intake was defined as such that while both boy and girl start eating, the boy is given much more food than the girl or for example, head of fish/bigger fish is given to the boy instead of the girl. Discrimination in education was defined by the respondents as when a boy is given more priority compared to a girl, and work-related discrimination means that household work that is considered as valueless is for females and work for earning is for males.

On the other hand, adolescent boys from non-ADP areas did not have any knowledge on gender except knowledge of compulsory education for both boys and girls. The reason for not knowing was explained in that they did not read about it anywhere, and were not given any information or training about these issues. A boy mentioned, *"What is gender, and gender discrimination is not known to me because I did not learn about it from anywhere and I have no idea about it."*

Influential persons (school teachers) from ADP and non-ADP areas did not have complete knowledge on gender and gender discrimination. One of them mentioned, *"Gender refers to male and female and sometimes it also refers to inanimate object such as chair, table, book, note book, hills, rivers, etc."* The person who did not have knowledge on gender discrimination would, however, know about compulsory education for boys and girls. They did not know what health-related discrimination is

but still know about discrimination in food intake. A 'community influential' from a non-ADP area mentioned, *"I never hear the word gender. When wife is ill, the servant does all the household work, not me, as people will hate me if I do this."*

Control over household assets

The respondents were also asked about whether women have rights to any family assets. The answer of ADP boys and girls was yes. A boy told, *"According to Muslim family law what two women will get as share, this is what a man will get."* Another boy mentioned, *"Women get shares from husband and father."* From a non-ADP area a boy mentioned that women do have rights to land but how that property is divided between man and woman, and what type of property they should have, were unknown.

A 'village influential' (school teacher) from an ADP area knew about it. One mentioned, *"The woman has a right to land because a woman is also a child of her parents. After the death of a father if there is 10 decimals of land and if two brothers, one sister and mother are alive then land will be divided into parts. Mother will get two parts of 16 and sister will get half of what a brother will get. This is how land is divided."* According to them females inherit land from parents and husband and they also possess ornaments; above all women have right to all valuables while men have the right to parental property, homestead, land and trees. Similar knowledge was also found in the mother of an ADP girl in that area.

Decision on family planning

A question was asked about who should use family planning methods. The adolescent boys and girls answered that both (male-female) should use them. Adolescent girls had complete knowledge on this issue but adolescent boys from ADP areas did not know who should adopt family planning methods. On the other hand, 'village influential' people (school teachers) from ADP areas were also knowledgeable. One mentioned, *'Both husband and wife should adopt family planning methods.'* They also mentioned that males decide how many children families should have, but both husband and wife decide when they would have a child. Club members from ADP areas had good knowledge of family planning.

Domestic violence

ADP girls and mothers were knowledgeable about domestic violence. They knew about it from their family as well as other neighbouring families. On the other hand, most of the ADP and non-ADP boys failed to define what domestic violence is. A boy said, *"I have learned long ago about domestic violence, but I forgot it."* Village influential people from ADP areas did not know what domestic violence is and what type of punishment is there for this. A club member (village influential) mentioned the definition of domestic violence as such, *"Domestic violence means being envious of anyone. Suppose my wife has deposited some money which is spent by me without taking her permission."* But what type of punishment there is for violence against women was unknown.

Sexual harassment/abuse

The UNICEF survey indicate relatively low knowledge across the board regarding comprehensive knowledge of sexual harassment among adolescents and adult respondents. For example, as Table 3 indicates 39.6% of adolescent girls and 45.6% of adolescent boys in intervention sites and 61.9% of girls and 60.4% of boys in control sites reported they did not know what sexual harassment was. Among the adult respondents there were no significant differences in knowledge about sexual abuse among mothers and 'community influential' people.

It should however be noted that 73% of the mothers in intervention sites and 81% of mothers in control sites indicated they did not know what sexual abuse was. The related proportions of CI in control and intervention sites noting they did not know what sexual abuse was were approximately one-third. Fathers in intervention sites were significantly less likely to report not knowing what sexual abuse was (53.8%) in comparison to their control site counterparts (63.8).

What is sexual harassment was extracted more from in-depth interviews. Result shows that ADP girls were aware of the definition of sexual harassment and knew the punishment of the perpetrator. One of them mentioned, *"If a boy teases any girl in various ways, it is called sexual harassment."* Another girl defined it as, *"A girl is walking along the road and some naughty boy passes bad comments saying that the body of the girl is beautiful; this is sexual harassment."* On the other hand, non-ADP boys were not familiar with this concept. A boy stated, *"What sexual harassment means and what type of punishment is there for sexual harassment are not known to me because I did not learn about it."* The reason for not knowing was that the adolescent did not participate in the classes that were taken by peer leaders or did not read about it in a book, or that it was a rather sensitive issue. Therefore, boys and girls did not discuss it or did not consider it as a serious issue. The type of punishment for sexual harassment was found unknown by non-ADP respondents.

Table 3. Frequency of responses regarding definition of sexual abuse

	Peer leaders	Adolescents			
	Endline	Endline			
	Girls	Gilrs		Boys	
Indicators	I only	I	C	I	C
Sample size	96	961	960	261	288
Indecent behaviour that children and women experience	71.9	35.5^	20.7	18.0	12.8
Indecent or filthy words to them	36.5	26.1^	18.1	18.0	12.5
Body contact: pushing or touching body	26.0	15.8^	7.8	28.4^	20.1
Rape girl	5.2	3.7	1.3	8.0	5.6
Don't know	6.3	39.6	61.9	45.6	60.4

Note: C refers to Control group and I to intervention group. CI refers to community influentials .
^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq.

Some 'village influential' people from ADP areas did not know the definition of sexual harassment. One 'village influential' from an ADP area knew, however. He said, *"If a man does have sex with a woman without her consent, this is sexual harassment."* Another influential gave the definition, *"When a naughty boy has intercourse with a girl illegally or touches her body to disrespect her, this would be treated as sexual harassment."*

A 'village influential' from a non-ADP area also knew what sexual harassment is. He mentioned an example that one of his cousins loved a girl, but the girl did not love him. Every day he stood on the way to school to talk with the girl, and finally the girl stopped going to school and got married.

Dowry

Respondents were asked to explain what dowry is and what the laws in Bangladesh pertaining to dowry are. The overall results pertaining to dowry indicate that peer leaders at endline were significantly more likely to report that *'dowry is money that a bride's family gives'* in comparison to the baseline (Baseline 86.6%; endline 94.8%). Knowledge about the laws pertaining to dowry was significantly higher among peer leaders at endline compared to that among peer leaders at baseline.

Mothers, fathers and 'community influential' respondents in intervention sites were also, over time, more likely to reject dowry as a normative behaviour and to cease to justify the reasons for which it is paid, in terms of demands by the groom's family (compared to baseline and endline: mother 43.2 to 57.0%, father 33.8 to 46.3%, CI 38.5 to 59.3%)

In response to the questions on laws pertaining to dowry, both peer leaders and girls in intervention sites show remarkable improvements especially when compared to their baseline responses. Adolescent girls were in the 70% range at endline compared to being around 30% at baseline.

Among the adult respondents, mothers and 'community influential' people showed an increasing understanding of the laws pertaining to dowry. At baseline 50.0% of mothers in intervention sites reported that they did not know the laws. This proportions decline to 29.7% of mothers and 31.6% of fathers in intervention sites reporting they did not know the laws pertaining to dowry at endline.

Adolescent boys and girls were asked about the type of punishment for receiving and giving dowry was carried out by government. ADP girls and boys were found to have partial knowledge of the punishment for dowry transactions. Boys from non-ADP areas did not know what type of punishments there are for dowry.

'Village influential' club member did not know the punishment for receiving and giving dowry. Another 'village influential' from the ADP area mentioned, *"I did not know the nature of punishment for dowry because I did not read about it and also nobody told me."*

Mobility

ADP girls were asked *'what is mobility?'* One of the girls mentioned, *"Before joining the club I remained at home and now I go to club, participate in rally, what I did not know before I have learnt now. I can go to college coaching alone."*

They were also asked what places they were allowed to go alone within and outside their villages, taking into account restrictions that may apply at different times of the day. Findings appear that the peer leaders experienced remarkable increase in mobility between baseline and endline with only 16.7% reporting they were not allowed to go anywhere outside their villages at endline compared to 44.4% at baseline. There were significant differences in mobility with regard to going outside the village among girls between baseline and endline. These differences were true for both intervention and control sites. At baseline some 54.8% of the girls in intervention sites and 55.2% of the girls in control sites had reported they could not go anywhere outside their village. At endline approximately a third of the girls in both intervention and control sites reported they were not allowed to go outside their villages.

Implementing knowledge related to reproductive health and other issues

Implementation of knowledge was defined as such that there were some health and gender-related issues which could be shared with anyone and practiced themselves.

Personal health and hygiene

All ADP boys and girls practiced personal health and hygiene themselves and also advised the family, friends, neighbour and relatives to do so. Most of the members of their family were better informed and began to practice. The reason behind this was that it could ensure better health. The physical changes the boys experienced were taken care of properly, as stated by the boys. Now ADP boys and girls were aware of the changes and what to do during these cases and they did this although they faced some challenges. For example, boys became aware, if there was wet-dream how to handle and manage this properly. Now boys felt the changes and shared the changes including wet-dreams with their friends and this resulted in a change of traditional thoughts and beliefs with regard to that. It taught them that wet dreams and all other changes were not a disease and they did not need to consult doctors.

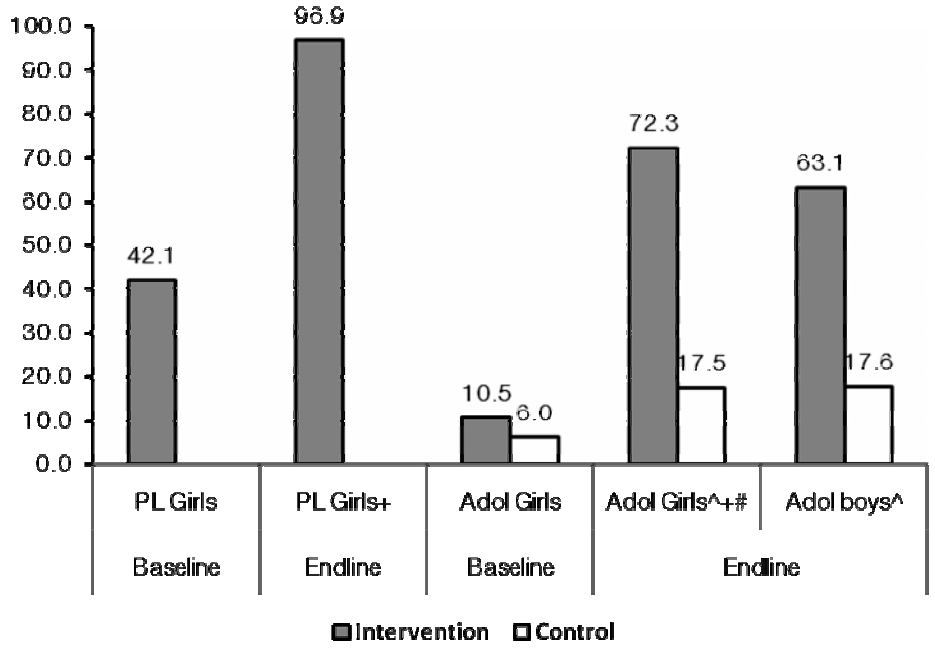
Family planning

Both ADP boys and girls shared information on family planning and its different methods with cousins, neighbours and relatives. One of them stated, *"I went to grandfather's home where I discussed the advantages of family planning with my brother's wife and aunt. I told them that if you have a small family you can easily educate your children, can give beautiful dresses, good and nutritious food."* In some cases boys tried to convince their neighbours to keep their family size smaller but failed. They still gave priority to sons and kept trying to have them. One boy stated, *"There was a family where for one son there are five daughters."*

Early marriage

Peer leaders (PL) and adolescents were asked what actions they had taken to prevent child marriage in their communities. Parents and 'community influentials' were also asked about actions they had taken. The proportions who reported taking any actions along with the most commonly reported responses by peer leaders are indicated in Figure 2.

Figure 2. Proportion those reporting actions relating to child marriage



Note: PL refers to Peer Leaders. Adol refers to adolescents and CI to community influentials.
^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq.
+ indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

The results on actions taken indicate that PL and 'community influential people' were the two groups who were most likely to report of taking actions. The main actions reported by the PL include talking to friends at *Kishori Kendro*, explaining demerits to groom's parents and protesting against early marriage. According to the 'community influential people' the main actions they have taken include explaining the demerits to groom's parents, explaining demerits to bride's parents, and protest against early marriage.

Whatever ADP boys and girls learnt from club and books they attempted to implement those in their lives. But in some cases adolescent girls were unable to prevent their early marriage despite having complete knowledge and sharing it with their parents. For example, one boy shared his knowledge with his cousin and neighbour to stop early marriage (Box 1).

Box 1.
One of my neighbours got her daughter married off. During the marriage I went to his father and discussed about the demerits of early marriage but his father and other neighbours argued that as a father he had got a good (eligible) bride for his son, the marriage has to take place. They did not pay attention to me.

'Village influential people' reported from ADP areas to have shared the knowledge on early marriage with their families and neighbours. In some cases they directly attempted to stop early marriage of their neigbours and some had been able to convince them by explaining the disadvantages of early marriage to parents who were about to get their daughter married before her legal age of marriage (Box 2). One of the village influential people mentioned, *"I endeavoured to stop early marriage but failed. Therefore, I advised them at least to register the marriage."* On the other hand, village influential people from non-ADP areas also shared their knowledge with their neighbours saying that they should not get their child married earlier than the legal age of marriage. One said, *"I don't tell anybody spontaneously about the demerits of early marriage, but those who have a 12-14 year old child who is healthy (and which seems older) is told not to get her married earlier than the legal age of marriage."*

Box 2.
Few days back a matchmaker came to a parent of my neighbour for his daughter's marriage who was 14/15 years old. I went to the parents and mentioned the demerits of early marriage. But they said that they got a good bridegroom. Then I said, you may lose your daughter to get a good bridegroom. Then the parents abstained from getting their daughter married.

HIV/AIDS and STD

Whatever was learnt from the ADP club both boys and girls shared with friends and sisters, neighbours, and relatives. One boy mentioned, *"I have shared knowledge on HIV with my friends and sisters that the person who is infected with HIV will contaminate others if he/she has an injection using the same syringe."* On the other hand, information on STDs was not shared with anyone. Most of the influential people of the village did not share knowledge about HIV and STD with anyone because they did not face problems, although 'village influential' from ADP and non-ADP areas shared their knowledge with their friends.

Birth and marriage registration action

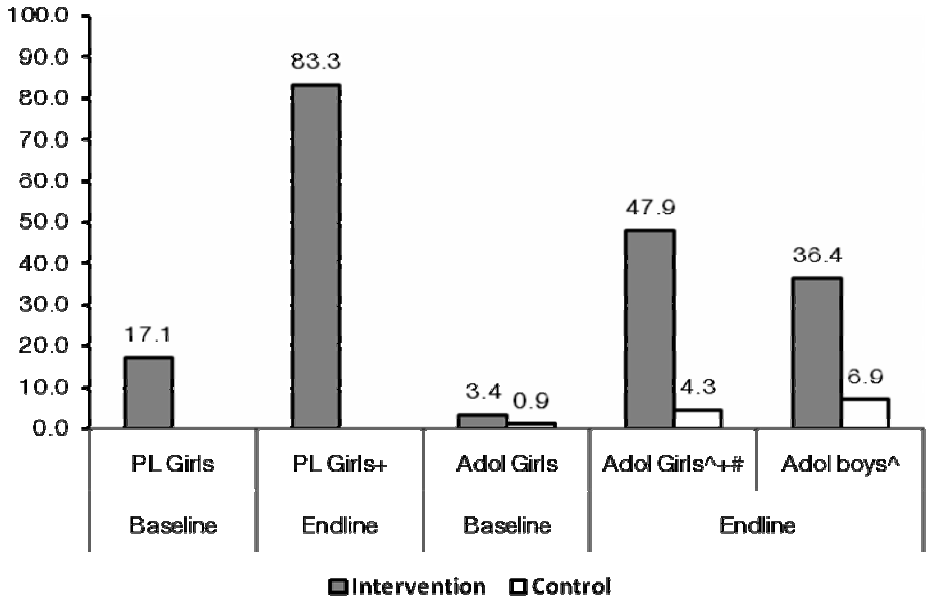
The PL and adolescent respondents were asked what actions, if any, they had taken to promote birth registration in their communities. Parents and community influential people were also asked to indicate what they had done in this regard. The reported

actions are significantly higher at endline compared to baseline for all respondents in the intervention sites. Interestingly the reported actions taken by mothers in intervention sites increased substantially from 4.6% at baseline to 47.8% at endline (fathers from 5.4 to 42.4% and 'community influential' taking action went from 39.8 to 80.1% in intervention sites).

The respondents were asked what actions, if any, that they had taken to promote marriage registration in their communities. Parents and community influential people were also asked the same question. Figure 3 shows the proportion who reported taking any actions along with the most commonly reported responses.

The reported actions pertaining to marriage registration were significantly higher at endline compared to baseline for all respondents in the intervention sites. The reported actions taken by mothers in intervention sites increased substantially from 8.1% at baseline to 37.5% at endline, the reported increase among fathers was relatively low, 10.8% of intervention fathers at baseline reported taking marriage registration actions compared to 37.7% of intervention fathers at endline. Also the changes in the proportion of community influential taking action went from 39.5 to 62.9% and the proportion of adolescent girls taking action went from 3.4 to 47.9% and peer leaders taking action went from 17.1 to 83.3% in intervention sites.

Figure 3. Proportion reporting actions relating to marriage registration



Note: PL refers to Peer Leaders. Adol refers to adolescents. CI refers to community influential.
^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq. + indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

Findings from in-depth interview show that knowledge on birth and marriage registration was shared with friends, relatives, and neighbours by both ADP girls and boys. One of them mentioned, *"I went to a bridal ceremony where I suggested that the marriage should be registered so that in any case she could resort to law* (Box 3)*."* Information on birth registration was also shared with girls explaining that without this service it would not be possible to go abroad or get admission into school. Village influential from ADP areas did the same and from non-ADP areas a few of them did not share the knowledge.

Box 3.
One of my uncles got married in late 2008, but he did not register the marriage. His wife did not get any *kabinnama*. After 5-6 months of his marriage he divorced his wife. His wife brought a cow and goat from her paternal home at the time of marriage. After divorce when she wanted to get them back her husband did not return those. She could not do anything because without marriage registration nobody took any action against the husband. If she had the legal marriage document (*Kabinnama*) she could take action against her husband. This is the first time I knew about marriage registration. Also I asked my parents about marriage registration. Now I realize the importance of marriage registration.

Gender and gender discrimination-related behaviour

This section includes broadly the prevalence of gender discrimination, control over assets, domestic violence and sexual harassment. The implementation of knowledge on the issues mentioned means that the respondents took actions to protest against behaviour which was against positive gender roles and relations.

Gender discrimination

It is always expected that knowledge of gender and gender discrimination leads to practicing opposing it, meaning that positive gender roles and relations are practiced in the household. If this does not happen according to the expectation there might have other reasons to prevent it.

Findings show that there was pervasive gender discrimination in the family mentioned by different respondents. An adolescent stated, *"In terms of work and earning boys/men are given more priority than girls/woman. For education-related decisions father's view was given importance or father exclusively took decisions about his daughter or son's education."* He also continued, *"Whenever anyone becomes sick, the father takes a decision, because he roams outside the home and has more knowledge and understanding compared to other members especially the mother in the family."*

A girl from an ADP area named Tamanna said, *"My father asked, what is the benefit of educating daughters so much? You will go to your father-in-law's house. Grand mother told that you will not prosper in life or earn money for the family, so you do not need to study more."* Another girl mentioned, *"I have one brother after four sisters, so he would eat much compared to us."* She also continued, "*My guardian (father) told me that you (me) do not need to have a private tutor. She also added*

that my brother studies at a good madrasa with boarding facility where English is also taught. Whereas I got admitted in a madrasa having only Arabic. I also believe that whatever we do by studying much may not help, as we have to go to a father-in-law's house and after that our study will be stopped."

Other ADP boys mentioned the practice of discrimination in his family as follows, *"When we start eating, mother gives me the head of the fish instead of giving it to my sister. But for education, my mother decides and gives me money as my father remains busy in the field. Besides, for treatment my mother takes care as she is the Shasthya shebika (Health volunteer) who has the phone number of the hospital."*

Embedded gender practice was found in food intake and division of labour. A boy mentioned, *"In my family cleaning dishes and all kinds of household work are performed by my mother."* The respondents also reported that division of work was clearly noticed in the family. Females were engaged in household activity and males were outside the home. Males did not do household work for two reasons: a) male remains busy in the outside activity and therefore, they did not have enough time; b) It is a matter of prestige for male to do domestic work which is supposed to be done always by females.

Boys from non-ADP areas also mentioned similar experiences in their family, where family members were dominated by males especially husbands for taking decisions regarding children's education, treatment and food intake, mobility including other types of decision. Traditional division of labour was also found to have been consistent in their family. A boy mentioned, *"My father is not interested to do household/domestic work."* Other boys mentioned, *"As my father remains busy with his business he does not have time to do it."*

Village influential people from ADP and non-ADP areas described similar findings on gender roles and relations. But a few of them pretended not have any discrimination in their family, saying, "I never discriminate between boys and girls in the family in terms of education, food intake and treatment, but boys can go around freely while girls do not. "*If mas-mansho (fish and meat) is cooked, all eat equally, nobody eats less compared to others."* While in the case of household work males always express lame excuses by saying that they were busy with outside home work. One of them stated in this regard, "*Dishes and clothes are cleaned by my wife. I did not do it since my boyhood, so I cannot do it."*

Decision making on assets

Regarding decision making in buying and selling household assets, gender discrimination was found dominant in ADP areas. It was reported that the male (husband) is the only person who decides to buy and sell household property. An adolescent told, "As father buys land in his name, only he decides to sell that." The adolescents also did not put his/her knowledge into practice. A boy mentioned, *"I do not say anything when someone deprives his wife from buying land in her name and also selling it because the land owner will not listen to me, or he will tell me that he*

does not need to discuss this matter with anybody. Besides, an adolescent would not be listened to as he/she is not mature enough or I am considered too young to understand land-related issues." Another boy said, *"When I share ideas about the reasons for the priority of husbands in the decision of buying and selling land with my father, in reply he told me that it is a tradition and it is practiced in this way. It is not happening suddenly. I have got land from my father and you will get from me."*

A similar picture was found in non-ADP areas regarding buying and selling land. A boy mentioned, *"In case of buying and selling land, males decide as the male manages money to buy assets and females do not know anything about this."*

A 'village influential' from the ADP area mentioned, *"Although women have the right to own property, they do not exercise this right. If a sister inherits 10 decimals of the total land, her brother tries to convince her saying that he can register all the land together. Thus, the sister is deprived of the land."* Another said, "*To buy land the male takes the decision but the female also sometimes contributes to the cost. Although females contribute in buying land, when it is sold the female never takes part or agrees because females mostly do not favour selling land. In this way the male is the only decision-maker."*

But a 'village influential' from a non-ADP area recognized female contribution in decision making. One mentioned, *"Both male and female contribute equally to make prosperity in life. For example, when I work in the field, my wife cooks for me and if she does not, what will happen?"*

Decision in marriage

In the UNICEF study, two sets of gender-related norms were considered in relation to decisions on marriage. The respondents were asked who should take decisions regarding the marriage of adolescents in one's family. The response categories included three options: men, women or both. At the same time the respondents (other than community influential) were also asked who actually took these decisions in their own families. Table 4 shows the responses related to gender norms around marriage decision. The response categories included three options: men, women or both. At the same time the respondents were also asked who actually took these decisions in their own families.

More than two-thirds (70.3%) of the adolescent girls in intervention sites were more likely to favour joint decision making when compared to 64.8% in control sites.

A similar pattern is found when asked who actually makes such decisions in their families. Significantly more adolescent girls reported that these decisions were made jointly (intervention72.9%, control 67.7%). These responses yielded significant changes between baseline and endline in the intervention sites for girls, but not in the control sites. For example, at baseline 63.3% of the adolescent girls in the intervention sites reported joint decision making as the norm in their households. At endline the corresponding proportion was 72.9%.

The results for parents and community influential respondents display similar trends. There were significant changes noted among the mothers, fathers and community influential respondents in intervention sites on attitudes and marriage-related decisions in the households. At baseline 69.1% of the mothers reported that 'joint decision making should be the norm' increased to 71.1% at endline. Similarly among fathers and community influential, 66.9% of the fathers and 79.1% of community influential people in intervention sites reported that joint decision making should be the norm. The corresponding figures at endline were 87.5 and 88.9% respectively.

Table 4. Gender norms around marriage decision making in the family

Indicator	PL		Adolescent					
	Baseline	Endline	Baseline		Endline			
	Girls	Girls	Girls		Girls		Boys	
	I only	I only	I	C	I	C	I	C
Who should take decisions regarding marriage of adolescents in the family								
Men	27.8	20.8	36.9	34.5	28.8	34.8	13.8	17.0
Women	0	0.0	1.0	1.0	0.8	0.4	0.4	0.3
Both	72.2	79.2	62.0	64.5	70.3	64.8	85.8	82.6
Who takes decisions regarding marriage of adolescents in the family								
	(Sig. +)				(Sig. g^+)			
Men	26.4	11.5	34.5	32.0	22.9	28.3	13.4	15.3
Women	5.1	4.2	3.2	3.9	4.2	4.1	3.4	4.9
Both	68.5	84.4	62.3	63.3	72.9	67.7	83.1	79.9
Sample size	216	96	1080	1078	961	960	260	288

Note: C refers to Control group and I to intervention group. PL refers to Peer Leaders. Adol refers to adolescents. CI refers to community influentials.^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq.+ indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

As far as the adult respondents are concerned, there appears to be significant changes in their attitudes in control sites as well. For example, in control sites at baseline some 62.6% of the fathers reported that decisions should be made jointly. In the same control sites at endline some 85.9% of the fathers reported the same.

Parents were also asked who actually makes the decisions related to marriage in their families. Fathers in intervention as in well as control sites reported significant changes over time in their responses. Some 73.3% of the mothers at baseline intervention sites reported that decisions were made jointly in their families. This proportion went up slightly to 75.3% at endline. Among fathers in intervention sites the increase between baseline and endline was from 67.9 to 89.9%. In control sites, some 66.6% of the fathers at baseline reported a joint decision making norm in their families compared to 88.3% of the fathers in control sites at endline.

These results also indicate that while among adolescent girls the perceived norms around decision making for marriage are changing, the change is more prominent in the intervention sites than in the control sites. For adult respondents, however, the

trends are significantly positive for both intervention and control sites, thus mitigating the impact of the KA intervention on these changes. It further appears from the preceding results on norms pertaining to decision making regarding marriage of adolescents that fathers are likely to assume that the normative behaviour that should be followed and is prevalent, is one of joint decision making. On the other hand mothers and adolescent girls are less likely to presume such a norm.

Comparisons between baseline and endline sites reveals significant changes in the proportions reported by PL over time only in relation to the question of who makes the decisions in their households. At baseline some 67.9% of the peer leaders had noted that such decisions were made jointly and at endline the proportion reporting joint decisions was 85.4%. Among girls there were significant changes over time on the question pertaining to who should make the decision and who actually made the decisions in their families. Some 59.7% of intervention adolescent girls at baseline compared to 69.7% of adolescent intervention girls at endline reported that decisions should be made jointly. Concurrently, 61.3% of them reported joint decision making in their families at baseline compared to 72.4% at endline.

Family planning

Using family planning methods was found to be mainly related to females as there is a norm that if males adopt the method, especially the permanent method, they could become weaker physically and could not do hard work. Regarding the decision about how many children will be born, this depends on the father and this is the rule of the day which has been practiced for ages in the society. The reason for many children was that children would in future take care of the parents. A boy mentioned, "*One of my cousins argued that he will have 8-10 children so that he will be taken care of in his old age."* But after sharing the information that had been received from the APON course, the cousin changed his decision.

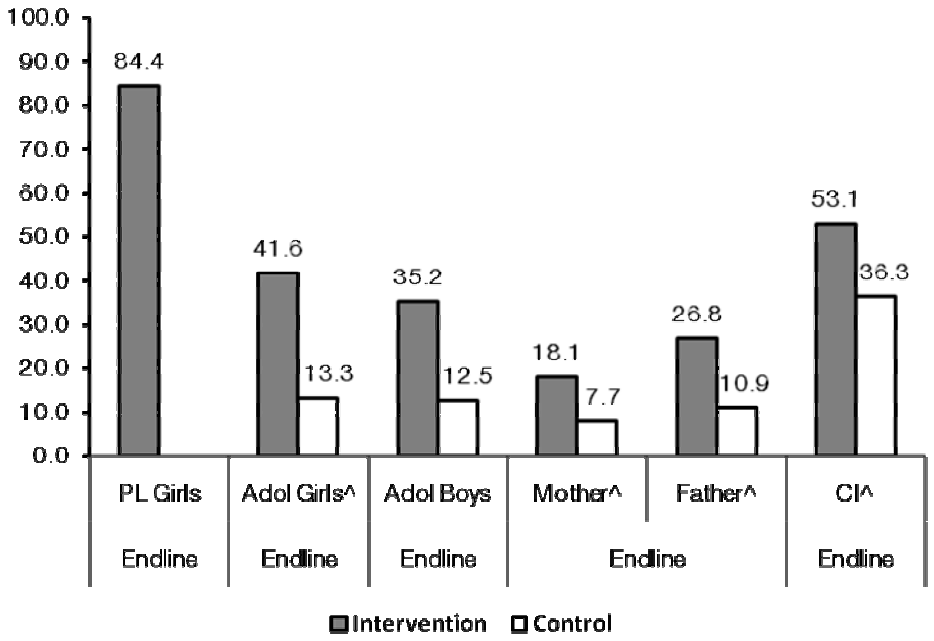
Boys from non-ADP areas mentioned that father is all in all in taking decisions and mother obeys father in order to make him happy. For number of sons both husband and wife took decisions. A village influential mentioned, *"What I have learnt from the ADP club is shared with my friends so that they take decisions on how many children there will be, on the basis of their economic condition.*"

Village influential from ADP and non-ADP areas expressed the idea that both husband and wife adopt family planning methods but in reality this is not happening. One of them said, *"Both husband and wife should adopt family planning methods, but most of the time the female (wife) uses this method. I myself do not use it because I am afraid of using the method, particularly ligation. If male does ligation he may be weakened and this is the reason not to use a family planning method."* The other member mentioned that he did not use any family planning method and, therefore, his wife has given birth to as many children as she has.

Sexual harassment

The UNICEF survey shows that some 84.4% of PL reported that they had taken some action on sexual harassment (Fig. 4). The most commonly reported actions were creating awareness of sexual abuse by discussing its bad effects. Figure 4 indicates that adolescents, mothers, fathers and community influential people in intervention areas reported significantly higher levels of actions regarding sexual abuse and exploitation when compared to their control site counterparts. The most commonly reported actions were creating awareness of sexual abuse, and discussions about the bad effects of sexual abuse. For example, the proportion of girls in intervention areas reporting actions were 41.6% compared to 13.3% of girls in the control sites. Among adolescent boys the intervention site proportion was 35.2% compared to 12.5% for boys in control sites. Among mothers and fathers in intervention sites the proportions reporting actions pertaining to sexual abuse and exploitation were 18.1% and 7.7% compared to 26.8% and 10.9% of mothers and fathers in control sites. Among community inlfuentials, 53.1 percent reported of taking action in the intervention sites compared to 36.3% in control sites.

Figure 4. Proportion reporting actions relating to sexual harassment



Note: PL refers to Peer Leader, Adol to Adolescent, CI refers to community influential.
^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq.

Experience of sexual harassment was found both in ADP and non-ADP areas. A boy mentioned, *"Two students from the same school were disturbing a girl on the way back home from school. Although the girl gave them a space to go they continued to disturb her."* Another boy also mentioned that his niece was disturbed by a boy (who was not a member of club). She was physically attacked by the boy. On the way to school the boy touched her body and they informed his guardian but he did not listen to them. Finally, the girl stopped going to school. He also mentioned a story of sexual harassment (Box 4). Boys were also reported to have been abused by girls, saying, *"Look at Bhutta (short size) boy."*

Box 4.
A girl member of a club named Shahnaz was sexually harassed by Rana from the same village. He behaved like mad to get her married. He threw himself at the feet of Shahnaz's mother and requested to get married. He also expressed that wherever Shahnaj would go he would like to go with her. He was also desperate to have heroin, ganja and wine to get Shahnaj. He was beaten to make him stop harassing her but did not pay attention to it. Therefore, she left school and went to another area.

Dowry

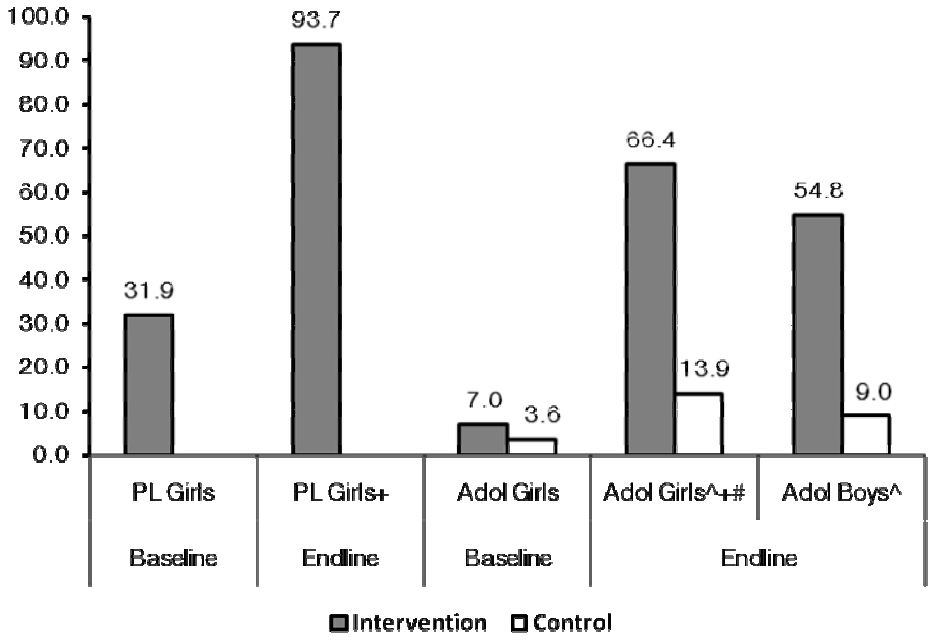
The respondents were asked what actions, if any, they had taken to prevent the giving/receiving of dowry in their communities (Fig. 5). Over 93.7% of PLs reported having taken dowry related actions at endline, the most commonly reported PL actions were: talking to friends at *Kishori Club* and in the community and explaining to parents of brides and grooms about dowry. A higher proportion of adolescent girls in the intervention sites reported taking action when compared to adolescent boys. The proportions taking action in the intervention sites compared to the control site was much higher for all types of respondents (Adolescent girl: Intervention site 66.4%; Control site 13.9%. Adolescent boy: Intervention site 54.8%; Control site 9.0%. Mother: Intervention site 44.6%; Control site 15.6%. Father: Intervention site 45.6%; Control site 22.3%. CI: Intervention site 77.5%; control site 54.1 percent).

In-depth interviews show that although there is a law against dowry the practice has not been stopped. During marriage, money, property, ornaments, furniture, etc. were given and taken as dowry. An adolescent mentioned, *"There was a girl who was married off by giving Tk.50,000 as dowry. On the other hand, a boy got married with Tk. 100,000 as dowry."* Another adolescent mentioned, *"One of my cousins took Tk.50,000 from the bride as bride price. When there was a quarrel between them, the cousin's wife asked for the money and wished to leave home. I told my uncle it would happen if you take dowry. In reply he said, today Tk. 50,000 is not an amount that is given even during the marriage of a fakir (penniless person)."*

A village influential mentioned, *"I did not take any dowry in my marriage but I failed to stop dowry transactions. I forbade them to take or give dowry. Because of dowry there are quarrels between the wife and other members in the family. Wife does not respect husband saying that you (husband) run the family by taking property from my father. Even then the dowry is not stopped."* He also said, *"With dowry a household*

gets the son married near home. Without dowry it is said that a good bride cannot be obtained. But it is also true that if dowry is given and received, that harms the family."

Figure 5. Proportion of respondents reporting actions relating to dowry



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Domestic violence

All respondents were asked whether in various situations husbands were justified in hitting their wives. The respondents were presented with seven circumstances, which are if she goes out without telling him; if she neglects the children; if she argues with him; if she refuses to have sex with him; if she burns the food; if she does not follow his instructions and if she does not do her work." Responses were clubbed together into three categories - those reporting no to all the circumstances, those reporting yes to 1-3 of the circumstances, and those reporting yes to 4 or more of these circumstances.

There were significant differences between baseline and endline in the intervention sites as far as justification of wife beating was concerned among all the respondents. All the respondents in intervention sites were more likely to report that wife beating was never justified. There were changes noted in control sites as well with all

respondent types in control sites also being less likely to justify wife beating in any circumstances at endline compared to baseline.

Overall these results indicate improving trends in reducing the justification for wife beating over time. However, these improvements were visible in both intervention and control sites. In addition, the fact that over a quarter of the mothers and adolescent boys regardless of location easily justified wife beating in virtually every circumstances leads one to question gender norms among adults and adolescents.

There were significant changes between baseline and endline in either control or intervention site adolescents in terms of witnessing physical abuse in their homes. Some 27.1 percent of peer leaders reported witnessing abuse in their homes at endline compared to 40.3% of PL at baseline (Table 5). There were also declines in the intervention sites reports of witnessing violence among adolescent girls. Some 40.1% of the girls at baseline compared with 27.1% at endline reported witnessing abuse in their homes. When asked about their personal experience with physical abuse, 44.3% of adolescent girls reporting being physically abused at endline compared to with 53.4% of intervention girls at baseline.

Table 5. Perceived prevalence of domestic violence

Indicator	PL		Adolescent					
	Baseline	Endline	Baseline		Endline			
	Girls	Girls	Girls	Girls	Girls		Boys	
	I only	I only	I	C	I	C	I	C
Proportion of women/mothers ever physically abused	40.3	27.1+	40.1	34.4	27.1+	29.2#	31.7	36.0
Proportion of adolescents ever physically abused	56.5	49.0	53.4	53.0	44.3^+	50.0	76.2	75.3
Sample size	216	96	1080	1078	961	960	260	288

Note: C refers to Control group and I to intervention group. PL refers to Peer Leaders.
^ indicates significant differences in two areas at endline in proportions at <.05 level determined using chi-sq.+ indicates significant differences between baseline intervention and endline intervention in proportions at <.05 level determined using chi-sq. # indicates significant differences between baseline control and endline control in proportions at <.05 level determined using chi-sq.

Remarkably high level of personal abuse was reported by the adolescent boys. Over 75% of them in both intervention and control sites reported to be physically abused. At the same time at endline, half of the PL and four out of 10 adolescent girls reported of being physically abused at endline. These high levels of reported abuse among boys and girls require urgent attention.

IV. Conclusion

Significant difference was observed in the respondents' knowledge on the subjects considered between ADP and non-ADP areas. In other words, knowledge of the respondents from ADP areas was much higher compared to non-ADP areas. The level of knowledge was also found better and more in-depth in ADP areas than in non-ADP areas. On the other hand, similar type of change was found in the case of gender roles and relations in both areas.

With regard to implementing knowledge in the respondents' lives, the result shows that more respondents shared knowledge with household members, relatives, friends, and neighbours. They also tried to convince them not to continue practices that were not congenial to reproductive health and positive gender roles and relations. The results also show that there was significant difference in the implementation of knowledge between ADP and non-ADP areas. Mostly the respondents from non-ADP areas were less aware about reproductive health and the issues related to it, including gender roles and relations, and also there were many reasons of not sharing and implementing the knowledge they had.

The reason for not sharing the knowledge related to reproductive health especially physical changes, menstruation/wet-dreams, pregnancy, family planning, etc. was that these issues are treated as a private matter and societal norms, culture and values that are patriarchal do not allow open discussion with anybody. Most of the respondents especially girls were shy and looked at one another when raising the issue in the group discussion. Sometimes the mother or grandmother of the girls was guarding them and stayed with the girls to hear what would be discussed in the meeting. In this case it was found that most of the girls were silent during the discussion of these so-called sensitive issues. This happened in both ADP and non-ADP areas but all of the girls from non-ADP areas were much more unwilling to discuss these issues compared to ADP areas.

About the issues mentioned, school teachers including guardians were also not interested to discuss with the adolescents. They thought that adolescents would be derailed by this discussion. A student mentioned, *"Madam (the teacher) told in the class that you learn about family planning issues at home, besides it will not come or be given in the exam."* Besides, these issues were shared especially with friends and *bhabi* (brother's wife) and it was not possible to do this with more senior people. An ADP girl stated, *"If it is discussed with someone more senior, they would call us beadob (naughty)."* Besides, at the age of adolescence there are lot of physical changes taken place among boys and girls. These physical changes and the related issues cannot be discussed openly. A girl mentioned, *"Even school teachers, madam in the girl's school is not interested to discuss the physical changes and reproductive health in the class".* Another boy said, *"Sometimes a guardian tears the page where it is written about reproductive health and physical changes."*

On the other hand, knowledge of ADP girls and boys, mothers and village influential people on gender and gender discrimination was shared with their family members especially with parents. Despite sharing these issues gender discrimination was found evident in their households. In non-ADP areas almost all adolescents were not aware of gender and gender discrimination. What information they had was not shared or implemented in reality. The implementation of knowledge with the issues as mentioned by the respondents was not possible because of the patriarchal system that prevails in the society. In this system the male decides everything of the family and societal matter which has been discussed in detail in the theoretical part of this report. The theoretical discussion has explained why adolescent girls – particularly women fail to turn their knowledge into practice.

In some cases other factors play a role in not implementing knowledge on gender-related issues. For example ADP boys and girls and others were aware better of the effect of early marriage and knew the legal age of marriage for boys and girls, but the respondents in most cases failed to stop early marriage. The factors that were responsible for this were that if the girl gets older she will face difficulty to get a bridegroom. The bridegroom might charge more dowry. There would have social pressure, meaning that people would make various comments to the girls including parents that might be difficult to bear for them. Finally, the girl might run away with any boy or have a sexual relationship which would be shameful for the family or lineage as well.

So, from the findings and conclusion it is clear that the ADP programme should continue to emphasize the increase of knowledge not only of the ADP girls and boys but also of the community people so that they might help to change their traditional behaviour with regard to reproductive health and gender discrimination, violence against women and sexual harassment. This is because increase of knowledge will have an impact on changing human behaviour in the end, although sometimes it may not happen due to different reasons. The Adolescent Development Programme should also focus on parents, guardians, school teachers and community leaders to change their embedded perceptions and attitudes towards the learning which is given to the adolescent boys and girls, and continue to strengthen and increase their involvement with the programme.

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