THESIS

ON

Knowledge of Sexual and Reproductive Health among Rohingya Refugee Girls aged 12-17 years in Cox's Bazar, Bangladesh

This thesis is prepared for the partial fulfillment of the Master of Public Health (MPH) Degree of One Health Institute, Chattogram Veterinary, and Animal Sciences University, Bangladesh

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Roll No: 0120/11

Registration No: 893

Session: 2020-2021

A thesis submitted in the partial fulfillment of the requirements for the degree of Master of Public Health (MPH)

One Health Institute

CHATTOGRAM VETERINARY AND ANIMAL SCIENCES UNIVERSITY

CHATTOGRAM-4225, BANGLADESH

DECEMBER, 2022

Statement of the Author

I, Md. Majharul Hoque, declare that, this thesis entitled, **Knowledge of Sexual and Reproductive Health among Rohingya Refugee Girls aged 12-17 years in Cox's Bazar, Bangladesh** is submitted to the One Health Institute of Chattogram Veterinary and Animal Sciences University for the partial fulfillment of the requirements of the Master of Public Health (MPH) degree. All content of the thesis is copyright material of the author if not referenced or acknowledged. Use of the material may only be made with the permission of the author, and the author preserves all rights to make any change in the original document.

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This is to certify that we have examined the above Master's thesis and have found that is complete and satisfactory in all aspects and that all revisions required by the thesis examination committee have been made.

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ACKNOWLEDGEMENT

This thesis presents the devoted presence of many people. I am incredibly grateful to the Almighty for the splendid opportunity that has allowed me to pursue the coursework of the MPH program offered by the renowned educational institution Chattogram Veterinary and Animal Sciences University, Chattogram, Bangladesh.

I would like to express my profound gratitude to my learned and experienced supervisor Dr. Mohammad Yousuf Elahi Chowdhury, Professor & Head, Department of Medicine & Surgery, Faculty of Veterinary Medicine of Chattogram Veterinary and Animal Sciences University, for his kind supportive supervision and proper guidance. I sincerely acknowledge Dr. Sharmin Chowdhury, Professor, Department of Pathology and Parasitology, Faculty of Veterinary Medicine & Director, One Health Institute for her kind cooperation, valuable advice. I am also grateful to all officials in the One Health Institute and Chattogram Veterinary and Animal Sciences University.

Last but not the least, all the credit goes to my parents, who never stopped believing in me and inspired me always.

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ABSTRACT

Background: The Rohingya people of Myanmar are among the most persecuted groups in society today. They have been subjected to government-sponsored discrimination, detention, abuse, and torture since receiving citizenship denial in 1982. The Rohingya community in Bangladesh resides in congested temporary housing with poor access to healthcare. Numerous variables, such as an increase in gender-based violence, a lack of knowledge about Sexually Transmitted Infections (STI), young marriages, risky sexual activities, and restricted access to STI testing and treatment facilities, have an impact on the general health of the Sexual and Reproductive Health (SRH). To avoid SRH problems in these circumstances, accurate knowledge is crucial. For individuals who are vulnerable, such as girls between the ages of 12 and 17, this is essential. The aim of this study was to evaluate the level of SRH knowledge among Rohingya girls aged 12 to 17 living in these camps in Bangladesh.

Methodology: A cross-sectional study was conducted in Rohingya refugee camp 3, ukhia, Cox's Bazar Bangladesh. A total of 362 Rohingya refugee females aged 12-17 years were included in this study. They were selected conveniently. A semi-structured questionnaire was used to collect data from the respondents.

Results: Our study determined, the overall knowledge about sexual and reproductive health among the Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh was 21.8% (79 participants, $n = 362$). Associated risk factors were age (in years) ($\beta = 0.367$, $p = <0.001$), parental educational status ($\beta = 0.346$, $p = <0.001$), and average monthly income ($\beta = 0.168$, $p = 0.002$).

Conclusion: Rohingya refugees females aged 12-17 years have very poor awareness of SRH. The degree of knowledge is directly related to the younger age, having illiterate parents and lower monthly income. Urgent community based approach, continual health promotion, and increasing awareness is needed to overcome this situation.

ABBREVIATIONS

UNHCR: United Nations High Commissioner of Refugees

STI: Sexually Transmitted Infection

SRH: Sexual and Reproductive Health

ARSA: Arakan Rohingya Salvation Army

SDGs: Sustainable Development Goals

CHAPTER I
INTRODUCTION

1.1 Introduction

One of today's most oppressed communities in the world is the Rohingya of Myanmar. They have been denied citizenship since 1982 and have experienced government-sponsored discrimination, detention, violence, and torture. As a result, they have fled in large numbers to Bangladesh in various waves, the most recent of which was in 2017. Nearly 700,000 Rohingya entered Bangladesh after the sudden influx on August 25, 2017. (Bhatia et al., 2018). According to UNHCR, 926,561 individuals are now living in 26 refugee camps in Cox's Bazar and Bhasan char, Noakhali (GoB-UNHCR, 2022c). As of February 2022, a total number of 64,749 girls aged 12-17 years old are living in those refugee camps, which is 7% of the total population (GoB-UNHCR, 2022b; UNHCR, 2022).

In addition to difficulties with food and nutrition security, research indicates that women refugees are frequently at high risk of rape, unintended pregnancies, and sexually transmitted illnesses. There is evidence that many women in refugee settings have significant reproductive health issues. These include making an early sexual debut, taking sexual risks such as several sexual partnerships and having sex without the use of a condom, unwanted pregnancies, and dealing with exploitation in the lack of conventional socio-cultural restraints. UNHCR has designated unwanted pregnancy as a critical reproductive health concern in emergencies (Ganle et al., 2019). Indeed, being a refugee could raise young girls' sensitivity to sexual and reproductive health concerns in a variety of ways.

Bangladesh's Rohingya population lives in overcrowded temporary shelters with inadequate access to healthcare. In such circumstances, there is a considerable likelihood of exploitation and exposure to communicable diseases, such as STIs. This is due to a variety of factors, including increased gender-based violence, poor understanding of STIs, underage marriages, hazardous sexual behaviors, and limited access to STI testing and treatment facilities (Khan et al., 2021).

Accurate knowledge of sexual and reproductive health is essential in these situations to prevent SRH issues. This is crucial for those who are at risk, such as girls between the ages of 12-17 years. For creating programs to raise awareness and offer guidance for those who work in healthcare and social organizations in Rohingya camps, it is essential to have a clear understanding of the knowledge these people have regarding SRH. The purpose of this study was to assess the level of SRH knowledge among Rohingya girls residing in these camps in Bangladesh who are 12 to 17 years old.

1.2 Study Objectives

1.2.1 General Objective

To measure the level of knowledge of sexual and reproductive health among Rohinga refugee children aged 12-17 years in Cox's Bazar, Bangladesh.

1.2.2 Specific Objectives

- To investigate the sociodemographic characteristics among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.
- To calculate the overall knowledge about sexual and reproductive health among Rohingya refugee female aged 12-17 years in Cox's Bazar, Bangladesh.
- To describe the association between sociodemographic characteristics and level of overall knowledge of sexual and reproductive health among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.
- To identify the level of knowledge about menstruation and pregnancy among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.
- To examine the level of knowledge about contraceptive methods among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.
- To investigate the level of knowledge about sexually transmitted diseases among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.

1.3 Justification of the Study

The well-being of adolescents depends on sexual and reproductive health, which is closely related to the basic of human rights. The SRH diseases are considered as important public health issues in growing countries, particularly among the displaced people, with significant psychosocial consequences. The Rohingya refugee girls live in challenging situations due to a lack of proper socioeconomic rights. Deficiency of proper knowledge, lack of credible information, and scarcity of societal awareness among them regarding SRH issues and densely populated living conditions subjected them to a very vulnerable state of getting affected by many communicable disease and sexual violence. Until now, no such study has been conducted on assessing the knowledge of SRH in Rohingya refugee girls of Bangladesh. Therefore, this study aims to measure the knowledge of the sexual and reproductive health among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh.

1.4 Operational Definitions

Sexual and Reproductive Health: A state of total physical, mental, and social well-being in all aspects pertaining to the reproductive system is considered good sexual and reproductive health. People require access to correct information and their preferred safe, effective, economical, and acceptable method of contraception in order to preserve their sexual and reproductive health (Zamrodah, 2016). A sufficient understanding of important SRH subjects and issues is considered good SRH knowledge (Jitendra Kumar Meena, Anjana Verma, Jugal Kishore, 2015).

1.5 Research Question (s)

What is the level of knowledge of sexual and reproductive health among Rohingya refugee girls aged 12-17 years in Cox's Bazar, Bangladesh?

CHAPTER II
REVIEW OF LITERATURE

Rohingya Refugees:

The Rohingya have been suffering for more than 200 years. Three periods can be used to categorize the history of the Rohingya: precolonial, colonial, and postcolonial. From 788 to 810 AD, Muslim Arab sailors settled in the autonomous kingdom of Arakan (now known as the Rakhine state), followed by Bengalis from the fifteenth to the seventeenth centuries (Milton et al., 2017). The Rohingya and Arakanese (the rest of the Arakan population) coexisted peacefully before European colonization. Following the first Anglo-Burmese War in 1825, colonization by the British brought about a change in this. The division widened during World War II when the Arakanese supported the Japanese while the Rohingyas sided with the British (Mahmood et al., 2017; Milton et al., 2017).

When the Burmese military junta initiated Operation Dragon King in 1978 to expel refugees and illegal immigrants, particularly the Rohingya, it marked the beginning of the mass emigration of Rohingya. It caused 250,000 people to flee as a result. In 1982, four years later, Burma passed its Citizenship Law. 135 "national races" were granted citizenship, but the Rohingya were left out, making them legally stateless. The military of Burma launched Operation Clean and Beautiful Nation in 1991 with the same goal of expelling the Rohingya from the Rakhine state. Following anti-Rohingya operations, hundreds of thousands of them were forced to flee into Malaysia, Thailand, Bangladesh, and other Middle Eastern nations in order to avoid persecution (Ty, 2019). The expulsion of the Rohingya was initiated by the late president Ne Win, and little has changed in the way that Ne Win's successor has treated the Rohingya. The Rohingya are considered illegal Bengalis by the Myanmar government, which also engaged in ethnic cleansing and genocidal acts against them in 2007 (Zahed, 2021).

As hundreds of Rohingya drowned at sea while attempting to travel by boat to Thailand and Malaysia in 2007, the Rohingya gained attention from the international media and the concern of human rights organizations as "new boat people" (Ty, 2019).

Extremists of the Bama ethnic group and Rakhine Buddhist fundamentalists joined up with Myanmar's security forces to carry out the so-called clearance operations, which got underway on August 25, 2017. They were a direct reaction to the Arakan Rohingya Salvation Army's (ARSA) attacks on 30 police and military sites in northern Rakhaing on August 24, 2017. Due to military raids, more than 725,000 Rohingya had sought safety in Bangladesh by September 2018 (Bhatia et al., 2018; Rawal et al., 2021; Ty, 2019).

Since August 2017, Bangladesh has been sheltering this forcibly displaced population, and as of right now, the UNHCR estimates that there are about 950,972 Rohingya refugees living in the different camps in Cox's Bazar & Bhasan char, Bangladesh (GoB-UNHCR, 2022a). People who are relocated forcibly frequently experience problems with their human rights and physical health, including a loss of access to essential services like healthcare, education, and employment possibilities as well as restricted mobility (Rawal et al., 2021).

Sexual and reproductive health:

Women and girls are the most vulnerable and at-risk population during wars and conflicts because rape, sexual abuse, human trafficking, and brutality are employed as military tactics. They endure great suffering because of the limited supply and high demand of reproductive health services, including as prenatal care, aided delivery, and emergency obstetric care. The lack of family planning services for many refugee women exposes them to unintended pregnancies. Managing sexual and reproductive health (SRH) inequities for the impacted, especially for women and adolescent girls, is essential for improving health outcomes and quality of life in unstable situations like the humanitarian catastrophe (Ahmed et al., 2020).

An institutional-based cross sectional study conducted by Zakaria et al. 2020 identified that the older adolescent girls' level of knowledge on puberty, family planning, maternal health, and HIV/AIDS was unsatisfactory. Menstruation-related misconceptions are widespread in rural areas, which place a number of limitations on adolescent girls and adult women. This study also revealed that older adolescent girls' high levels of knowledge in Chattogram, Bangladesh were substantially correlated with reading about or watching SRH issues in the media, living in an urban area, and having regular SRH communications with their mother, sister, or friend (Zakaria et al., 2020).

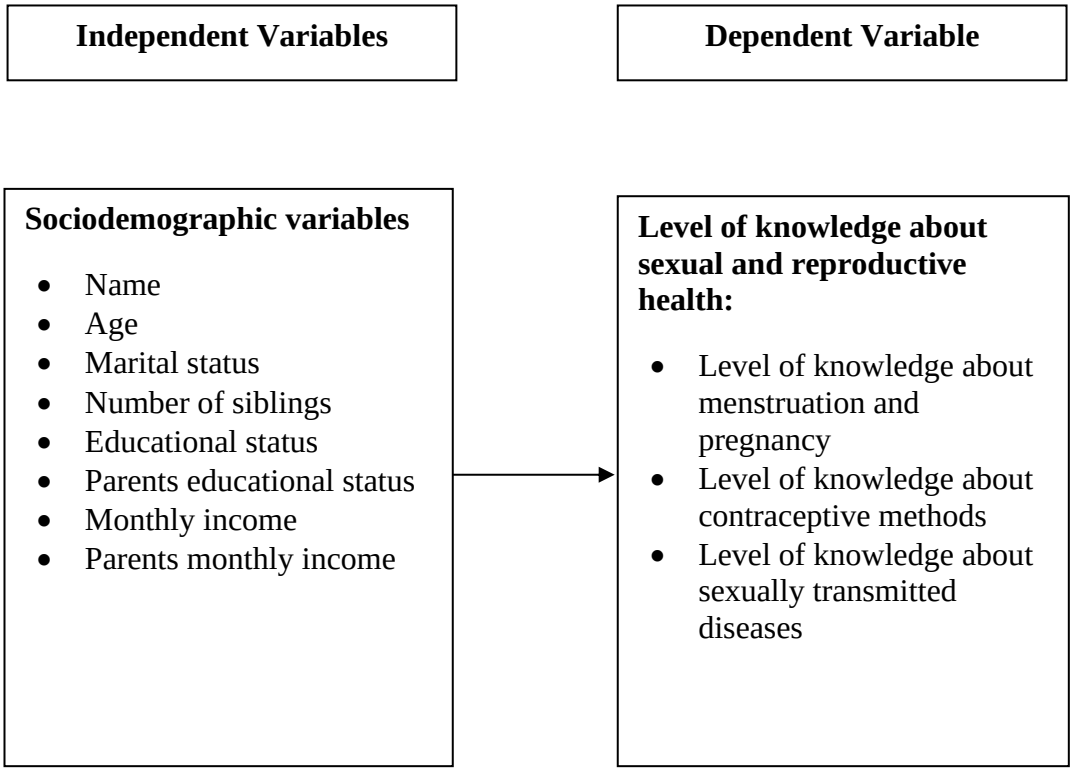
Al Maharma et al. 2019 conducted a study to measure the level of knowledge about SRH among Syrian refugee mother. They found the knowledge of and attitudes concerning STIs among the moms were shown to be marginally positively correlated. Despite having generally positive attitudes regarding STIs, Syrian refugee moms lacked knowledge of STIs' non-HIV origins and clinical signs. The length of the marriage, the amount of time the couple had been refugees in Jordan, the moms' awareness of STIs, and attitude all had a substantial impact on the spouse's willingness to use a condom. Nearly all mothers of Syrian refugees (91.6%) and their partners (95%) did not follow regular STI check-ups. Sixty-six percent of moms' spouses oppose using a condom during sexual activity (Al-Maharma et al., 2019).

A systemic review of 24 qualified papers conducted by M. Çöl et al. 2020 described about the sexual and reproductive health of Syrian refugee women in Turkey. They identified, the percentage of congenital unions was 56%. Younger than 18 marriages were common. Between 18 and 20 was determined to be the average age at first marriage. The amount of prenatal treatment was insufficient. In Syria, married women of all ages used contemporary contraceptives at a rate of 24%. There were around 35% of unmet family planning needs. About half of the patients brought to gynecology outpatient clinics were said to have abnormal vaginal discharge. About 8% of sexual assaults were reported. Only 20% of Syrian women regularly visited a gynecologist (Çöl et al., 2020).

CHAPTER III

MATERIALS AND METHODS

3.1 Conceptual Framework



3.2 Study Design

A cross-sectional study was conducted.

3.3 Target Population & Sample Population

The target population of this study was the Rohingya refugee girls aged 12-17 years who currently live in the refugee camps in Cox's Bazar, Bangladesh.

3.4 Study Site & Area

The study was conducted at the Rohingya Refugee Camp No: 3, Ukhia, Cox's Bazar, Bangladesh.

3.5 Study Period

October 2021 to June 2022 (9 Months).

3.6 Sample Size

According to UNHCR, 64,353 Rohingya refugee female aged 12-17 years are living in various refugee camps in Bangladesh until September 30, 2022 (*UNHCR Population Factsheet Block Level Data - Sep 2022*, n.d.). Until now, there is no such study on knowledge about sexual and reproductive health among the displaced children here in Bangladesh although few studies have been done among other. After reviewing them we assume 62% (Zakaria et al., 2020) proportion in population to compute the sample size using the following formula:

$$n = z^2 \frac{pq}{d^2}$$

$$n = z^2 \frac{p(1-p)}{d^2}$$

$$n = (1.96)^2 \frac{0.62(1-0.62)}{(0.05)^2}$$

$$n = 362.032384 = 362$$

Here,

$n =$ Desired sample size

z = Standard Normal variation (at 95% confidence level, it is 1.96)

$p =$ Proportion in population based on previous study

$q = 1\text{-}p$

$d =$ Precision (in case of 5% allowable error, it is 0.05)

3.7 Inclusion Criteria

Rohingya refugee girls aged 12-17 years living in the camp no: 3, Ukhia, Cox's Bazar were included in this study.

3.8 Exclusion Criteria

1. Rohingya refugee girls aged 12-17 years whose parents did not give consented to participate in this study.

2. Rohingya refugee girls aged 12-17 years who were not cooperative during the study.

3.9 Sampling Technique

A random sampling method was used for this study.

3.10 Data Collection Tools

A semi-structured questionnaire was used to collect socio-demographic data for this study and a 4 points Likert scale was used to measure the level of knowledge about sexual and reproductive health among the study population. The maximum score will be 57 and minimum can be 0. Bellow 39 will be regarded as poor knowledge and ≥ 39 will be regarded as good knowledge.

3.11 Data Management & Analysis Plan

Statistical analysis were performed using SPSS V25. Demographic characteristics were described as the frequency and we conducted a Chi-square test to analyze the association between different responses and outcomes. We performed binary logistic regression to calculate the odds ratios (ORs) and the corresponding 95% confidence intervals (95% CIs) to analyze the univariate associations between sociodemographic characteristics and level of knowledge about sexual and reproductive health outcome. All tests were two-sided, and $p<0.05$ was regarded as statistically significant.

3.12 Quality Control & Quality Assurance

The following measures were adapted for quality control and assurance.

- A standard research etiquette of the One Health Institute, Chattogram Veterinary and Animal Sciences University was followed.
- Regular help and guidance had been taken from the Supervisor.
- The Field Supervisor (FS) monitored all field activities.
- The designed questionnaire had been pretested or piloted, translated, and simplified.
- The data had been checked and rechecked for validity and reliability. The supervisor rechecked at least 5% of the collected data to monitor the data quality.
- Manipulation of data had been strictly prohibited. The data were closely monitored, maintained confidentially, and stored on a password-protected device. However, only the research team had access to the data.
- The data had been inspected manually to assure the data accuracy during coding and cleaning,

The researchers performed the data collection, analysis, and report writing.

3.13 Ethical Considerations

- Ethical clearance had been acquired from the Institutional Review Board (IRB)/Ethical Review Committee (ERC)/the One Health Institute, Chattogram Veterinary and Animal Sciences University, with the Department Chair's signature for this study.
- The authorities of the respective study sites had been approached for permission to proceed with the data collection.
- Each participant had been briefed about the study's objectives before data collection. We ensured the privacy and confidentiality of the participants.
- Informed written/verbal consent had been attained before the data collection.
- Since participation in this study had been voluntary, the participants could withdraw from the interview at any moment.
- Confidentiality of the information given by the participant had been preserved.
- The ethical theory transcribed in the 1964 Declaration of Helsinki and its updates observed.

3.14 Limitations of the Study

We can suppose that some sexual behaviors were underreported since SRH is sensitive and socially stigmatized among Rohingya refugees. Due to the participants' limited literacy, data were gathered through face-to-face interviews. One reason for keeping certain essential and crucial information a secret would be embarrassment. Self-administered surveys offer a more private and nonthreatening way to report sensitive activities, which minimizes response bias. Due to their adherence to the privacy code in the Quran and Islamic teachings, all study participants were Muslims and were therefore unlikely to discuss private sexual topics outside of the privacy of their homes. The findings' ability to be generalized was constrained by the use of practical sampling.

CHAPTER IV

RESULT

A total of 362 Rohingya refugee female aged 12-17 years living in the refugee camps at Cox's Bazar, Bangladesh participated in this cross-sectional study. It determined the overall knowledge about Sexual and reproductive health and investigated the association between sociodemographic factors on knowledge about sexual and reproductive health among the 12-17 years aged Rohingya refugee female in Cox's Bazar, Bangladesh.

Figure 1 displays the overall knowledge about sexual and reproductive health among the Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh. Accordingly, the overall good knowledge about sexual and reproductive health was determined as 21.8% (79 participants, *n = 362*).

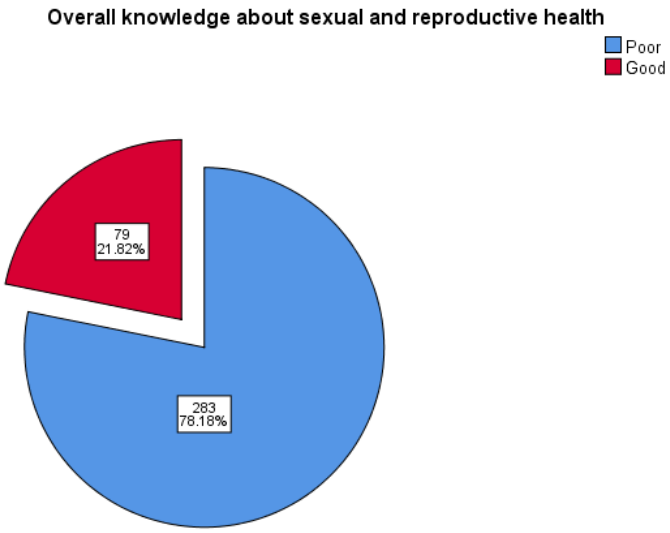


Figure 1: Knowledge about sexual and reproductive health among the Rohingya refugee female aged 12-17 years in Cox's Bazar, Bangladesh

5.1 Frequency Distribution and Chi-square test:

Table 1: Frequency distribution and effects of sociodemographic characteristics on knowledge about sexual and reproductive health

Independent variables	Dependent variables		Total	X^2	*p*
	Poor knowledge	Good knowledge			
	(Value, %)	(Value, %)			
Age (In Years)				156.612	<0.001
12-14	111 (100%)	0 (0.0%)	111		
15-16	123 (95.34%)	6 (4.66%)	129		
17	49 (40.1%)	73 (59.9%)	122		
Marital status				5.590	0.133
Married	50 (68.4%)	23 (31.6%)	73		
Unmarried	230 (80.7%)	55 (19.3%)	285		
Divorced	0 (0.0%)	3 (100%)	3		
Widowed	0 (0.0%)	1 (100%)	1		
Number of siblings				13.393	0.004
1-3	56 (71.79%)	22 (28.21%)	78		
4-6	168 (78.5%)	46 (21.5%)	214		
7-9	57 (89.06%)	7 (10.94%)	64		
≥10	2 (33.33%)	4 (66.67%)	6		
Educational status				28.143	<0.001
Illiterate	174 (88.77%)	22 (11.23%)	196		
Literate	109 (65.66%)	57 (34.34%)	166		
Parental educational status				172.008	<0.001
Illiterate	277 (90.22%)	30 (9.78%)	307		
Literate	6 (10.9%)	49 (89.1%)	55		

Average monthly income (In BDT)				187.212	<0.001
No income	279 (90%)	31 (10%)	310		
1-4999	2 (4%)	48 (96%)	50		
5000-9999	0 (0.0%)	1 (100%)	1		
≥10000	0 (0%)	1 (100%)	1		
Parental average monthly income (In BDT)				50.422	<0.001
No income	162 (93.1%)	12 (6.9%)	174		
1-4999	43 (55.12%)	35 (44.88%)	78		
5000-9999	71 (71%)	29 (29%)	100		
≥10000	7 (70%)	3 (30%)	10		
Primary source of knowledge				51.405	<0.001
Parents	125 (92.59%)	10 (7.41%)	135		
Friends	57 (91.93%)	5 (8.07%)	62		
CHW	71 (62.28%)	43 (37.72%)	114		
Others	30 (58.82%)	21 (41.18%)	51		

Table 1 shows the frequency and effects of sociodemographic characteristics on knowledge about sexual and reproductive health among the Rohingya refugee female aged 12-17 years in Cox's Bazar, Bangladesh. In this study, the maximum number of participants (129 participants, 35.6%, *n = 362*) were in the age group of 15-16 years. The age of the 111 participants, (30.7%, *n = 362*) was between 12-14 years and the age of the rest 122 participants (33.7%, *n = 362*) were 17 years old.

The distribution of sociodemographic characteristics on knowledge about sexual and reproductive health among Rohingya refugee female aged 12-17 years was also displayed in table 1. 73 (20.2%, *n = 362*) and 6 (1.7%, *n = 362*) participants whose age were respectively 17 years and between 15-16 years, had over all good knowledge about sexual and reproductive health.

Table 1 reveals that, 285 (78.7%, *n = 362*) participants were unmarried and 73

participants (20.2%, *n = 362*) were married. Rest 3 participants (0.8%, *n = 362*) and 1 participants (0.3%, *n = 362*) were respectively divorced and widowed.

Table 1 also shows the distribution of participants according to marital status. Among unmarried participants, 55 (15.2%, *n = 362*) had overall good knowledge about sexual and reproductive health. Only 23 participants (6.4%, *n = 362*) among married participants had overall good knowledge about sexual and reproductive health. Only 1 divorced Rohingya refugee female aged 12-17 years had overall good knowledge about sexual and reproductive health.

Table 1 also demostrated, maximum number of the study participants (214 participants, 59.1%, *n = 362*) had 4-6 siblings in their family. 78 participants (21.5%, *n = 362*) had 1-3 siblings, 64 participants (17.7%, *n = 362*) had 7-9 siblings in their families. Only 6 participants (1.7%, *n = 362*) had 10 or more than 10 siblings.

46 Participants (12.7%, *n = 362*) who had 4-6 siblings also had overall good knowledge about sexual and reproductive health. 22 (6.1%, *n = 362*) and 7 (1.9%, *n = 362*) participants having 1-3 and 7-9 siblings respectively, also had over all good knowledge about sexual and reproductive health. Only 4 Rohingya refugee female aged 12-17 years who had 10 or more than 10 siblings, had overall good knowledge about sexual and reproductive health. The frequency of illiterate participants is more than the frequency of literate participants. (Illiterate: 196, 54.1% vs Literate: 166, 45.9%, *n = 362*).

In this study, we discovered that only 22 (*n = 362*, 6.1%) participants who were illiterate had overall good knowledge about sexual and reproductive health. On the other hand, 57 (*n = 362*, 15.7%) literate participants had overall good knowledge about sexual and reproductive health. We also discovered, that 55 (15.2%, *n* = 362) Rohingya refugee females aged 12-17 years had literate parents, but 307 (84.8%, *n* = 362) participants had illiterate parents (Figure 10). Among them, 49 (13.5%, *n = 362*) and 30 (8.3%, *n = 362*) females having respectively literate and illiterate parents had overall good knowledge about sexual and reproductive health. Table 1 demonstrated us, that the maximum number of study participants (310, 85.6%, *n = 362*) had no income. 50 (13.8%, *n* = 362) participants had an average monthly income between 1-4999 BDT. 1 participant (0.3%, *n = 362*) earned between 5000-9999 BDT, and another 1 participant (0.3%, *n = 362*) earned 10,000 or more than that average in a month.

Table 1 stated that 48 participants (13.3%, *n* = 362) who had an average monthly income between 1-4999 BDT had overall good knowledge about sexual and reproductive health. Only 31 participants (8.6%, *n = 362*) having no income had overall good knowledge about sexual and reproductive health.

The parents of 100 (27.6%, *n = 362*) and 78 (21.5%, *n* = 262) participants' average monthly income was between 5000-9999 BDT & 1-4999 BDT respectively. The average monthly income of the parents of only 10 participants (2.8%, *n = 362*) was 10000 BDT or more than that. The rest of the 174 participants (48.1%, *n = 362*) had parents who had no income (Table 1).

Table 1 demonstrated, that only 3 participants (0.8%, *n = 362*) having a parental average monthly income of 10000 BDT or more than that had overall good knowledge about sexual and reproductive health. 29 (8.0%, *n = 362*) and 35 (9.7%, *n = 362*) participants who had a parental average monthly income of 5000-9999 BDT and 1-4999 BDT respectively also had overall good knowledge about sexual and reproductive health. Only 12 (3.3%, *n* = 362) participants having parental no monthly income had overall good knowledge about sexual and reproductive health.

Table 1 reveals that the primary source of knowledge of 135 (37.3%, *n* = 362) study participants was their parents. Among them, only 10 (2.8%, *n = 362*) had overall good

knowledge about sexual and reproductive health. 62 (17.1%, *n = 362*) study participants' primary source of knowledge were their friends. Among them, only 5 had overall good knowledge. 114 (31.5%, *n = 362*) study participants' primary source of knowledge were CHW. Among them, 43 (11.9%, *n = 362*) had overall good knowledge. 51 (14.1%, *n = 362*) study participants got their knowledge from other sources. Among them, 21 (5.8%) had overall good knowledge about sexual and reproductive health.

Table 1 also exhibits the association between sociodemographic variables and overall knowledge about sexual and reproductive health outcomes among the Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh.

The chi-square test demonstrated that there was a statistically remarkable variance between the overall knowledge about sexual and reproductive health and most of the sociodemographic attributes of the study population which are age (in years), number of siblings, educational status, parental educational status, average monthly income, parental average monthly income and primary source of knowledge. (Respectively, $X^2=156.612$, $p=<0.001$; $X^2=13.393$, $p=0.004$; $X^2=28.143$, $p=<0.001$, $X^2=172.008$, $p=<0.001$, $X^2=187.212$, $p=<0.001$, $X^2=50.442$, $p=<0.001$ and $X^2=51.405$, $p=<0.001$).

However, there was no noteworthy variation in the middle of the overall knowledge about sexual and reproductive health outcomes and the participant's marital status ($X^2=5.990$, $p=0.133$).

5.2 Logistic regression analysis

Variables that were statistically significant in Table 1 were included in the linear regression analysis. Table 2 shows the result of the logistic regression analysis.

Table 2: Result of logistic regression analysis

Independent variables	*OR*	*p*	95% CI	
			Lower	Upper
Age (In Years)		*<0.001*	0.147	0.230
12-14	17.447			
15-16	19.928			
≥17	1			
Number of siblings		*0.506*	0.029	0.058
Educational status		*0.043*	0.002	0.131
Parental educational status		*<0.001*	0.259	0.537
Illiterate	6.247			
Literate	1			
Average monthly income		*0.002*	0.065	0.294
No income	4.546			
1-4999	4.491			
5000-9999	4.162			
≥10000	1			
Parental average monthly income		*0.007*	0.012	0.074
Primary source of knowledge		*0.860*	-0.031	0.026

The logistic regression analysis results are projected in table 2. According to table 2, Knowledge about sexual and reproductive health among Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh is directly associated with some socio-demographic variables. Age (In years) (*p = <0.001*), parental educational status (*p = <0.001*), and average monthly income (*p = 0.002*) are the factors that are directly associated with knowledge about sexual and reproductive health among Rohingya refugee children aged 12-17 years in Cox's Bazar, Bangladesh.

Table 2 also described, poor knowledge about sexual and reproductive health found 17.447 & 19.928 times higher in 12-14 & 15-16 years respectively than ≥17 years Rohingya refugee females. Parental educational status had an impact over SRH knowledge. Poor SRH knowledge found 6.247 times higher in the females who had illiterate parents than those who had literate parents. 12-17 years Rohingya refugee females who had no income, income of 1-4999 & 5000-9999 had more likely to had poor SRH knowledge 4.546, 4.491 & 4.162 times higher than those who had an average monthly income of ≥10000 BDT.

Table 3: Level of knowledge about different sexual and reproductive health

	Poor knowledge	Good knowledge	Total
	Frequency (%)	Frequency (%)	Frequency (%)
Level of knowledge about menstruation & pregnancy			
	245 (67.68%)	117 (32.32%)	362 (100%)
Level of knowledge about contraceptive methods			
	303 (83.70%)	59 (16.30%)	362 (100%)
Level of knowledge about sexually transmitted diseases			
	330 (91.16%)	32 (8.84%)	362 (100%)

Table 3 described, only 117 participants (32.32%, *n = 362*) had a good level of knowledge about menstruation and pregnancy. On the other hand, 245 respondents (67.68%, *n = 362*) had poor knowledge of menstruation and pregnancy.

There is a huge difference between the frequencies of poor and good knowledge about contraceptive methods among Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh. According to table 3, only 59 participants (16.30%, *n = 362*) had good knowledge, but 303 respondents (83.70%, *n = 362*) had poor knowledge regarding the contraceptive methods.

Table 3 also described, there is also huge difference between the frequencies in the level of knowledge about sexually transmitted diseases. Figure 21 shows, only 32 (8.84%, *n = 362*) Rohingya refugee females aged 12-17 years had good knowledge regarding sexually transmitted disease. On the other hand, 330 (91.16%, *n = 362*) had poor knowledge about sexually transmitted diseases.

CHAPTER V
DISCUSSION

One of the main objectives of the Sustainable Development Goals (SDGs) is to improve the sexual and reproductive health (SRH) of adolescent girls (Zakaria et al., 2020). The SRH, maternal health, and child health of adolescent girls are influenced by adequate and accurate knowledge.

This study seeks to examine the amount of SRH knowledge among Rohingya refugee females aged 12 to 17 in Cox's Bazar, Bangladesh, in light of this. We found that, 21.82% participants had overall good knowledge about sexual and reproductive health. This discovery is in line with others. For instance, Bano and Al Sabhan discovered that 62.5% of girls who attended a university in Saudi Arabia, where religious conservatism predominates, similar to Bangladesh, were unaware of this natural occurrence until menarche (Bano & Al Sabhan, 2015).

Hakem et al. discovered that in India, girls aged 13 to 19 who attended non-government schools knew about the menstrual cycle before menarche, compared to 48.8% of girls who attended government schools. Parents in Bangladesh have historically believed that pubertal changes, including menstruation, are a normal stage of human development that should be kept a secret from teenagers before they undergo physical and psychological changes (Hakim et al., 2017).

Our study also revealed that, age (In years) ($p = <0.001$), parental educational status ($p = <0.001$), and average monthly income ($p = 0.002$) are the factors that are directly associated with knowledge about sexual and reproductive health among Rohingya refugee children aged 12-17 years in Cox's Bazar, Bangladesh.

We also identified, Poor knowledge about sexual and reproductive health found 17.447 & 19.928 times higher in 12-14 & 15-16 years respectively than ≥17 years Rohingya refugee females. Parental educational status had an impact over SRH knowledge. Poor SRH knowledge found 6.247 times higher in the females who had illiterate parents than those who had literate parents. 12-17 years Rohingya refugee females who had no income, income of 1-4999 & 5000-9999 had more likely to had poor SRH knowledge

4.546, 4.491 & 4.162 times higher than those who had an average monthly income of ≥10000 BDT.

Age (in years), parental educational status and average monthly income are the associated sociodemographic factors with overall knowledge about sexual and reproductive health knowledge among Rohingya refugee females aged 12-17 years in Cox's Bazar, Bangladesh. This finding is also aligned with previous studies done globally (Al-Maharma et al., 2019; Iqbal et al., 2017; Kwankye et al., 2021).

CHAPTER VI

CONCLUSION AND RECOMMENDATION

Refugee women from Rohingya experience extremely challenging living conditions. Natural calamities and pre-existing medical issues are significant barriers. Because of their crowded living conditions, lack of knowledge, and lack of trustworthy information, parents are particularly prone to the effects of several health problems, including STDs. One of the most significant global public health issues is SRH. Women who are Rohingya refugees and are between the ages of 12 and 17 have very little awareness of sexual and reproductive health. The degree of knowledge is directly related to a number of risk factors. Younger age and having illiterate parents are two sociodemographic characteristics that cannot be changed that directly affected SRH knowledge. Lower average monthly income is a modifiable risk factor that has a big impact on SRH knowledge. There is an urgent need for a community-based approach in the Rohingya refugee camps in Cox's Bazar, Bangladesh. The continual SRH health promotion actions are essential due to the significantly lower level of information. To increase awareness of the risk factors for scabies and for successful management, it is crucial to conduct appropriate health education programs for the female Rohingya refugees.

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APPENDICES

APPENDIX-A

Inform Decision Making Consent Form (English)

Identification No…… **Date...../...../.....**

Name of Respondent ……

I, Md. Majharul Hoque, student of the MPH program of One Health Institue, Chattogram Veterinary and Animal Sciences Univeristy, am researching **"Knowledge of Sexual and Reproductive Health among the Rohingya Refugee girls aged 12-17 years in Cox's Bazar, Bangladesh".** As a part of this study, your and your child's participation would be highly appreciated and would contribute a lot to this research study. You and your child will be asked to answer several questions. Your and your child's identity will not be disclosed and will be kept confidential.

Your and your child's participation in this study will not involve any inconvenience or risks. If any questions asked to you or your child during the study poses embarrassment or discomfort, you are free to refuse to answer those questions. Your and your child's participation is voluntary. Refusal to participate or withdrawal of your consent or discontinue participation in the study will not result in any penalty or loss of benefits. The results of this study will be presented anonymously.

One Health Institute, Chattogram Veterinary and Animal Sciences University has reviewed and approved the procedures of this study. If you have any questions about this study, you should feel free to ask now or anytime throughout the study. If you have understood the nature of the study and have agreed to participate, please sign in the place, indicated below. Thanking you,

Parent/Guardian signature & date **Investigator signature & date**

Appendix - B

Inform Decision Making Consent Form (বাংলা)

সনাক্তকরণ নংঃ..... তারিখঃ...../...../.....

গবেষনায় অংশগ্রহণকারীর নামঃ.....

প্রিয় সুহৃদ, আমি মোঃ মাজহারুল হক, ওয়ান হেলথ ইন্সটিটিউট, চট্টগ্রাম ভেটেরিনারি এন্ড এনিমাল সাইন্সেস ইউনিভার্সিটি এর এমপিএইচ প্রোগ্রামের ছাত্র । আমি একটি গবেষণা কর্ম করছি যার শিরোনাম হল "**Knowledge about Sexual and Reproductive Health among Rohingya Refugee gorls aged 12-17 years in Cox's Bazar, Bangladesh**" । আমি আপনাকে এবং আপনার সন্তানকে এই গবেষণায় অংশগ্রহণের আমন্ত্রণ জানাচ্ছি। আপনাকে এবং আপনার সন্তানকে উক্ত গবেষণা কর্মে কিছু প্রশ্নের উত্তরও দিতে হবে যা এই ফর্মে উল্লেখ করা আছে।

আমি আপনাকে জানাতে চাই যে এটি সম্পূর্ণরূপে একটি একাডেমিক গবেষণাকর্ম এবং আপনার এবং আপনার সন্তানের প্রদত্ত তথ্য সমূহ অন্য কোন উদ্দেশে ব্যবহৃত হবে না। আপনার এবং আপনার সন্তানের নাম প্রকাশনায় গোপন থাকবে।

এই গবেষণা কর্মে আপনার এবং আপনার সন্তানের অংশগ্রহণ ঐচ্ছিক এবং গবেষণাকর্মের যেকোন সময় এতে অংশ নেয়া থেকে বিরত থাকতে পারবেন। ইন্টারভিউ চলাকালীন কোন নির্দিষ্ট প্রশ্নের উত্তর না দিতে চাইলে, প্রশ্নের উত্তর না দেয়ার অধিকার আপনি এবং আপনার সন্তান সংরক্ষণ করেন।

আমি আপনার সহযোগিতায় কৃতজ্ঞ থাকব। আপনি যদি আপনার সন্তানকে এই গবেষণায় অংশগ্রণ করাতে সম্মত হন, তবে অনুগ্রহ পূর্বক নির্দিষ্ট স্থানে স্বাক্ষর করুন।

পিতামাতা/অভিভাবকের স্বাক্ষর ও তারিখ

তথ্য গ্রহণকারীর স্বাক্ষর ও তারিখ

APPENDIX-C

Questionnaire – English

Identification No:……

Part I: Socio-demographic characteristics		
Si No	**Questions**	**Answer / Response**
1.	Name	
2.	Age (years)	
3.	Marital status	☐ Married ☐ Unmarried ☐ Divorce ☐ Widowed
4.	Number of siblings	
5.	Educational status	☐ Literate ☐ Illiterate
6.	Parents educational status	☐ Literate ☐ Illiterate
7.	Monthly income (BDT)	
8.	Parents monthly income (BDT)	
9.	Who is your primary source of knowledge?	☐ Parents ☐ Friends ☐ CHW ☐ Others
Part II: Knowledge about sexual and reproductive health		
Part II.I: Knowledge about menstruation and pregnancy		
Si No	**Questions**	**Answer / Response**
10.	How much do you know about menstruation? • What age do period start? • Is it normal • How long is menstruation period? • Why do girls have period?	☐ Poor ☐ Average ☐ Good ☐ Excellent
11.	How much do you know about sanitary napkin? • What is sanitary napkin? • What are the advantages of it?	☐ Poor ☐ Average ☐ Good

		☐ Excellent
12.	How much do you know about pregnancy? • How someone get pregnant? • How long pregnancy last? • Can you tell some symptoms of pregnancy?	☐ Poor ☐ Average ☐ Good ☐ Excellent
13.	How much do you know about risk of pregnancy before the age of 18 years? • Is it safe to be pregnant before 18? • What will happen if someone get pregnant before 18 years?	☐ Poor ☐ Average ☐ Good ☐ Excellent
14.	How much do you know about the importance of antenatal and post-natal care visit during pregnancy? • What is ante & post-natal visit? • Advantages of them?	☐ Poor ☐ Average ☐ Good ☐ Excellent
15.	How much do you know about miscarriage of pregnancy? • What is miscarriage? • Can you tell some signs? • How do you suspect miscarriage?	☐ Poor ☐ Average ☐ Good ☐ Excellent
16.	How much do you know about the benefits of hospital delivery for both mother and child? • Is hospital delivery safe? • Advantages of hospital delivery?	☐ Poor ☐ Average ☐ Good ☐ Excellent
Part II.II: Knowledge about contraceptive method		
Si No	**Questions**	**Answer / Response**
17.	How much do you know about contraception or birth control method? • What does it mean?	☐ Poor ☐ Average ☐ Good

	• What are the types?	☐ Excellent
18.	How much do you know about condom? • What is it? • Advantages of it?	☐ Poor ☐ Average ☐ Good ☐ Excellent
19.	How much do you know about oral contraceptive pill? • What is it & its types? • Benefits of them? • Side effects of them?	☐ Poor ☐ Average ☐ Good ☐ Excellent
20.	How much do you know about Intra-Uterine Contraceptive Device? • What is it? • How long it prevent pregnancy? • Benefits of it?	☐ Poor ☐ Average ☐ Good ☐ Excellent
21.	How much do you know about Implant method? • What is it? • How long it prevent pregnancy? • Site of the implant?	☐ Poor ☐ Average ☐ Good ☐ Excellent
22.	How much do you know about permanent contraceptive method? • Is it for both male and female? • What are they for male and female? • Benefits of them?	☐ Poor ☐ Average ☐ Good ☐ Excellent
Part II.II: Knowledge about sexually transmitted disease (STD)		
Si No	**Questions**	**Answer / Response**
23.	How much do you know about STD? • How one's get STD? • Can you name some STD? • Symptoms of STD?	☐ Poor ☐ Average ☐ Good ☐ Excellent

24.	How much do you know that unprotected sexual intercourse can cause STDs? • What is unprotected sexual intercourse? • How can one get protection? • Risk of unprotected sexual intercourse?	☐ Poor ☐ Average ☐ Good ☐ Excellent
25.	How much do you know about AIDS? • What is it? • How can one get affected AIDS? • What will happen if anyone get AIDS? • How to get protection against HIV?	☐ Poor ☐ Average ☐ Good ☐ Excellent
26.	How much do you know about gonorrhea? • What is it? • Symptoms? • How is it spread?	☐ Poor ☐ Average ☐ Good ☐ Excellent
27.	How much do you know about syphilis? • What is it? • How ones get it? • Symptoms?	☐ Poor ☐ Average ☐ Good ☐ Excellent
28.	How much do you know that using condom can prevent most of the STDs? • Is condom safe? • Can it prevent STDs?	☐ Poor ☐ Average ☐ Good ☐ Excellent

APPENDIX – D

Questionnaire – বাংলা

সনাক্তকরণ নং:……

পর্ব ১০ঃ জনমিতি সংক্রান্ত তথ্য		
ক্রমিক নং	**প্রশ্ন**	**উত্তর / প্রতিক্রিয়া**
১.	নাম	
২.	বয়স (বছর)	
৩.	বৈবাহিক অবস্থা	☐ বিবাহিত ☐ অবিবাহিত ☐ তালাকপ্রাপ্ত ☐ বিধবা
৪.	ভাই-বোনের সংখ্যা	
৫.	শিক্ষাগত যোগ্যতা	☐ স্বাক্ষর ☐ নিরক্ষর
৬.	পিতা-মাতার শিক্ষাগত যোগ্যতা	☐ স্বাক্ষর ☐ নিরক্ষর
৭.	মাসিক আয় (টাকা)	
৮.	পিতা-মাতার মাসিক আয় (টাকা)	
৯.	আপনি প্রথম কার কাছে যৌন ও প্রজনন স্বাস্থ্য সম্পর্কে জেনেছেন?	☐ পরিবার ☐ বন্ধু ☐ সিএইচডব্লিউ ☐ অন্যান্য
পর্ব ২০ঃ যৌন এবং প্রজনন স্বাস্থ্য সম্পর্কিত জ্ঞান		
পর্ব ২.১০ঃ মাসিক এবং গর্ভধারণ সম্পর্কিত জ্ঞান		
ক্রমিক নং	**প্রশ্ন**	**উত্তর / প্রতিক্রিয়া**
১০.	আপনি মেয়েদের মাসিক সম্পর্কে কতটুকু জানেন? • কোন বয়সে পিরিয়ড শুরু হয়? • এটা কি স্বাভাবিক • মাসিক কতদিন হয়? • মেয়েদের পিরিয়ড কেন হয়?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১১.	আপনি স্যানিটারি ন্যাপকিন সম্পর্কে কতটুকু জানেন? স্যানিটারি ন্যাপকিন সম্পর্কে আপনি কতটা জানেন? • স্যানিটারি ন্যাপকিন কি? • এর সুবিধা কী?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো

১২.	আপনি গর্ভধারণ সম্পর্কে কতটুকু জানেন? • কিভাবে কেউ গর্ভবতী হয়? • গর্ভাবস্থা কতদিন স্থায়ী হয়? • আপনি কি গর্ভাবস্থার কিছু লক্ষণ বলতে পারেন?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৩.	১৮ বছর বয়সের আগে গর্ভধারণ করা ঝুকি সম্পর্কে কতটুকু জানেন? • ১৮ বছরের আগে গর্ভবতী হওয়া কি নিরাপদ? • ১৮ বছরের আগে কেউ গর্ভবতী হলে কি হবে?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৪.	আপনি গর্ভকালীন ও গর্ভপরবর্তী স্বাস্থ্য পরীক্ষা সম্পর্কে কতটুকু জানেন? • জন্মের আগে এবং প্রসবোত্তর সফর কি? • তাদের সুবিধা?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৫.	আপনি গর্ভপাত সম্পর্কে কতটুকু জানেন? • গর্ভপাত কি? • আপনি কিছু লক্ষণ বলতে পারেন? • আপনি কিভাবে গর্ভপাত সন্দেহ করেন?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৬.	হাসপাতালে শিশু জন্মদানে মা এবং শিশু উভয়ের সুবিধা সম্পর্কে আপনি কতটুকু জানেন? • হাসপাতালে ডেলিভারি কি নিরাপদ? • হাসপাতালে ডেলিভারির সুবিধা?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
পর্ব ২.২০ঃ জন্মনিয়ন্ত্রণ সম্পর্কিত জ্ঞান		
ক্রমিক নং	**প্রশ্ন**	**উত্তর / প্রতিক্রিয়া**
১৭.	আপনি জন্মনিয়ন্ত্রণ সম্পর্কে কতটুকু জানেন? • এর মানে কী? • প্রকারভেদ কি কি?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৮.	আপনি কনডম সম্পর্কে কতটুকু জানেন?	☐ খুব কম

	•এটা কি? • এর সুবিধা কি?	☐ কিছুটা ☐ ভালো ☐ খুব ভালো
১৯.	আপনি জন্মনিয়ন্ত্রণ বড়ি সম্পর্কে কতটুকু জানেন? • এটা কি এবং এর প্রকারভেদ? • তাদের সুবিধা? • এগুলোর পার্শ্বপ্রতিক্রিয়া?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২০.	আপনি জরায়ু অভ্যন্তরে জন্মনিয়ন্ত্রণ ডিভাইস সম্পর্কে কতটুকু জানেন? •এটা কি? • কতক্ষণ এটি গর্ভাবস্থা প্রতিরোধ করে? • এর উপকারিতা?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২১.	আপনি ইমপ্লান্ট জন্ম নিয়ন্ত্রণ পদ্ধতি সম্পর্কে কতটুকু জানেন? •এটা কি? • কতক্ষণ এটি গর্ভাবস্থা প্রতিরোধ করে? • ইমপ্লান্ট সাইট?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২২.	আপনি স্থায়ী জন্ম নিয়ন্ত্রণ সম্পর্কে কতটুক জানেন? • এটা কি পুরুষ ও মহিলা উভয়ের জন্য? • পুরুষ ও মহিলাদের জন্য তাদের নাম কি? • তাদের সুবিধা?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
পর্ব ২.৩০ঃ যৌনবাহিত রোগ সম্পর্কিত জ্ঞান		
ক্রমিক নং	**প্রশ্ন**	**উত্তর / প্রতিক্রিয়া**
২৩.	আপনি যৌনবাহিত রোগ সম্পর্কে কতটুকু জানেন? • একজন কিভাবে যৌনবাহিত রোগে আক্রান্ত হয়? • এমন কিছু রোগের নাম বলুন? • যৌনবাহিত রোগ এর লক্ষণ?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২৪.	অনিরাপদ যৌন মিলন যৌনবাহিত রোগে আক্রান্ত হওয়ার অন্যতম কারন সম্পর্কে আপনি কতটুকু জানেন?	☐ খুব কম ☐ কিছুটা

	• অনিরাপদ যৌন মিলন কি? • কিভাবে কেউ সুরক্ষা পেতে পারে? • অনিরাপদ যৌন মিলনের ঝুঁকি?	☐ ভালো ☐ খুব ভালো
২৫.	আপনি এইডস সম্পর্কে কতটুকু জানেন? • এটা কি? • কীভাবে একজন এইডসে আক্রান্ত হতে পারেন? • কেউ এইডস হলে কি হবে? • কিভাবে HIV এর বিরুদ্ধে সুরক্ষা পেতে হয়?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২৬.	আপনি গনোরিয়া সম্পর্কে কতটুকু জানেন? • এটা কি? • লক্ষণ? • কিভাবে এটি ছড়িয়ে পড়ে?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২৭.	আপনি সিফিলিস সম্পর্কে কতটুকু জানেন? • এটা কি? • মানুষ কিভাবে এতে আক্রান্ত হয়? • লক্ষণ?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো
২৮.	কনডম ব্যবহারে যৌনবাহিত রোগ অনেকাংশে প্রতিরোধ করা সম্ভব সম্পর্কে কতটুকু জানেন? • কনডম কি নিরাপদ? • এটা কি যৌনবাহিত রোগ প্রতিরোধ করতে পারে?	☐ খুব কম ☐ কিছুটা ☐ ভালো ☐ খুব ভালো