Ethics and Culture Towards Adolescent Sexuality, Abortion and Contraception Among Midwifery Students.

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Abstract

Introduction Values and attitudes of midwifery students towards adolescent sexuality, abortion, and contraception are sensitive issues because they are key health personnel in Bangladesh for promoting health services to adolescents in rural areas as well as in the urban areas of the country. The impacts of globalization through satellite TV channels, Hollywood movies, Internet etc. have rapidly changed the social norms and values of the adolescents in the country. A growing number of abortions, STDs and HIV/AIDS risks among youth and reproductive age people are posing major health concerns in the country. These serious problems need to be addressed. Hence, it is important to understand the future midwives' awareness and attitudes towards adolescent health issues in order to improve their education and training programs.

Objectives To investigate values and attitudes towards adolescent sexuality, abortion and contraception and views on professional preparation among Bangladeshi midwives.

Methods A questionnaire survey was conducted which includes 87 midwifery students from three nursing institutes from three different regions of the country. The study was carried out in February 2006.

Results The major finding is a general disapproval of adolescent pre-marital sexual relations and abortion. But there was also an empathic attitude and willingness to support young women who bear consequences of unwanted pregnancies and social condemnation. Gender-based imbalance in sexual relationships, limited knowledge about health issues among youth, and negative social attitudes were concerns expressed by the students. The students' future task will be to provide general health care services giving less priority to other reproductive health issues such as abortion and prevention of STDs and HIV/AIDS.

Conclusion Midwifery education in Bangladesh should encourage value-reflective thinking around gender inequity and ethical dilemmas, in order to prepare midwives to address adolescents' reproductive health needs.

Keywords Pre-marital sex, Adolescent abortion, values, Midwifery education, STD, HIV/AIDS, Bangladesh.

Introduction

There is increasing recognition that public health often provides an added and compelling justification for safeguarding human rights, despite the respect, protection and fulfillment which they merit in their own right. In the context of HIV/AIDS, an environment in which human right are respected, ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination and the personal and social impact of HIV infection is alleviated. Considering the obligations with regard to the rights of non-discrimination, health, information, education, employment, social welfare and public participation[1], government needs all members of civil society to confront difficult issues with a sense of urgency.

Adolescent sexual and reproductive health and rights have received much global attention during the last

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two decades[2]. Many of these issues among adolescents have become major public health problems globally and need to be addressed: unprotected sex leading to unintended pregnancies, abortions, and sexually transmitted infections (STI), including Human Immunodeficiency Virus (HIV)[3]. However, in many societies the response to pre-marital sexual relations is met with denial, prohibition and silence, and as a result services for unmarried adolescents remain inadequate[4, 5].

In about 25 years, since acquired immune deficiency syndrome (AIDS) was first identified, it has killed more than 22 million people worldwide. Till today, the number of HIV/AIDS cases in Asia remains relatively small. However, as the region contains more than 60 percent of the global population, large numbers of people are at great risk. Even small increases in prevalence could take a heavy toll in terms of the total numbers of people affected[6].

With adolescence, boys and girls reach their sexual maturity and the potential to initiate sexual activity. In traditional conservative society of Bangladesh, Bangladeshi parents are reluctant to discuss sexual matters with their adolescent children. The lack of school-based sex education programmes in Bangladesh further contributes to adolescents' poor understanding of sexuality and safe behaviors. As a result, many Bangladeshi adolescents have misperceptions about sexuality; this can lead to risk behaviour. Knowledge of reproductive health and contraception among adolescents, has been shown to be limited and both individual practice and social constraints, set barriers for adolescents to protect themselves.

"Under the Penal Code dating back to 1860, induced abortion is permitted in Bangladesh only to save the life of mother. Legalization of first trimester abortion on broad medical and social grounds was proposed in 1979, but legislators did not take action. In 1979, however, the Bangladesh Government included menstrual regulation (MR) in the national family planning programme and encouraged doctors and paramedics to provide MR in all government hospitals and health and family planning complexes"[7]. The Government considers menstrual regulation to be an "interim method of establishing non-pregnancy for a women at risk of being pregnant, whether or not she actually is pregnant"[8]. Nearly 8000 doctors and 6500 paramedics now provide MR services in government clinics throughout the country, in addition to those provides who work in private MR clinics. Despite the widespread availability of legal and safe MR services, however, many young women resort to illegal and unsafe abortion for social superstition. This report describes some aspects of the sexual and reproductive health situation of adolescent women in Bangladesh and summarizes the available data on young women's experiences with menstrual regulation and induced abortion[9].

Adolescent sexuality and abortion are considered highly moral issues, strongly embedded in conservative cultural norms and values, which create a moral predicament for health care providers in Bangladesh involved in providing health care services. Knowledge of reproductive health and contraception among Bangladeshi adolescents is inadequate and social constraints sets barriers for them to protect their own sexual and reproductive health. Strengthening the capability of mid-level health providers including midwives has been recognized internationally to improve the quality of reproductive health care services for all women especially for adolescents.

Midwives are a core group of professionals that meet the special needs of adolescents within reproductive health services[1]. According to a definition of the World Health Organization (WHO), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO), the midwife's professional responsibilities encompass sexual and reproductive health care in a life perspective[10]. Strengthening the competence of mid-level providers, including midwives, has been recognized internationally to be a cost-effective intervention towards improving the quality of reproductive health care for women[11, 12].

Government put emphasis on improving the situation of adolescent sexual and reproductive health strengthening the role and competence of midwives in providing reproductive health services, contraception and abortion counseling and care. In Bangladesh Midwifery education is based on a competitive entry system. A four years' Diploma of Nursing includes one year midwifery training for women and one year orthopedic training for men. To get admission to nursing curriculum, students require 10 years' basic education (secondary school certificate). Standards and regulations for nursing practice and upgrading of the educational system are currently being developed.

The concept of reflective practice is central within curricula development and has also become a requirement within many nursing and midwifery

programmes[13]. Adolescent sexuality and abortion are highly moral issues, embedded in cultural norms and values and subject to continuous changes taking place in society[14]. If the students' values regarding these issues, framed by the dominant moral climate in society, contrasts with changing reality, students may, as future health professionals, be placed in ethical dilemmas. To understand the nature of these dilemmas and the impact that they may have on those involved, the process of reflection has been widely used during the instruction of Ethics[15]. The reflective process provides students the opportunity to reflect on their personal values followed by a critical analysis of those values[16] and, consequently, new perspectives may be achieved[17].

The aim of the present study was to assess the midwifery students': (i) values and attitudes towards adolescent sexuality, abortion and contraception and (ii) their knowledge about sexually transmitted diseases (STDs) and HIV/AIDS with their respective education.

Methods

There is a total number of 38 Nursing Institutes in Bangladesh and all of these give midwifery education[18]. A convenience purposive selection of three nursing institutes and from these 3rd and 4th year students was included in the survey. The three schools are situated in three different region of the country. The Chittagong nursing institute is in the commercial capital city and main port of Bangladesh, which is 260 miles away from the capital Dhaka. The Mymensingh nursing institute is about two hours drive from capital and the Chuadanga nursing institute also 8 hours drive from the capital by road. Out of 261 (116 3rd year and 145 4th year) altogether of there selected institutions, only 30 students from each institution (15 for each year) totaling 90 were included in the survey for convenience. Students were earlier informed by their Principals about the aim of the study and their participation was voluntary and confidential. The study plan was later approved by the Bangladesh Medical Research Council (BMRC).

A structured questionnaire was developed and after pilot testing, the final questionnaire was prepared. The final questionnaire covered the socio-economic and demographic background of the students and questions regarding their attitudes towards pre-marital sex, abortion, use of contraception, degree of knowledge about sexually transmitted diseases (STDs) and HIV/AIDS and the source of sexual information. For questions regarding the degree of knowledge about STDs and HIV/AIDS, no standard pre-answer was set but participants were asked to fill-up 4 or 5 points they considered important or relevant. The questionnaire contained 48 statements and took around 20-25 minutes to complete. The questionnaire was distributed to each of the 15 (fifteen) 3rd and 4th year midwifery students of three different nursing institutes situated in three different districts of Bangladesh. So, a grand total of 90 (ninety) students were accepted to join in the survey but from which 3 (three) 3rd year students of Chittagong Nursing Institute refused to answer the questionnaire. Some students refused to answer some specific question for their personal inconvenience.

Most of the collected questionnaire data were quantitative. Therefore, manifold contingency tables are used to test the independence of the attributes. For example, students were classified into two classes - 3rd year students and 4th year students; and their knowledge level were classified into four classes - know all the causes/ways, know only greater causes/ways, limited knowledge and not aware at all. Chi-square - test was used to test whether the two attributes (e.g. year of the students and their knowledge level) are independent or not The data was processed and analyzed by SPSS (10 version) and some of the works have been done by MS Excel 2003 for calculation convenience. Means and proportions were calculated, and some inter-group comparisons were made. Chi-square - test was used in analyses that entailed comparison of proportions. *P-values* less than or equal to 0.05 were considered statistically significant.

Results

Results from the questionnaire survey are presented under following main headings: (i) profile of the students, (ii) attitudes towards pre-marital sexual relations, (iii) attitudes towards abortion and contraception, (iv) knowledge of sexually transmitted diseases (STDs,) and HIV/AIDS and (v) source of sexual information.

The backgrounds of the 87 midwifery students who participated in the study are shown in Table 1. All participants were female with a mean age of 20.5 (n=43) for 4th year students and 19.4 (n=39) for 3rd year students. Only three were living with their parents or uncle and the rest of the 84 students lived in institute dormitory/hostel with the mean time of 34 month (n=83). More than 88 percent were born in rural areas and the remaining in urban areas and their

mean age staying at birthplace was 14.4 year. They belonged to different religious believes. Out of 87 participants 59 were Muslim, 20 were Hindu, 6 were Buddhist and 2 were Christian of which only 4 students were married. One fourth of the participants' father's education level was below SSC (10th class) and half of their mother's education level below SSC. On the average they have the number 4.44 siblings being and 54 percent of them lived in extended families. Forty six percent of the student's family depends financially on their father's job, 27 percent family depends on other own income source and 27 percent families had more than one income sources.

Table 1: Socio-demographic information of the participants

	4th year students(n = 45)*	*3rd year students*(n = 42)*	*Overall*(n = 87)*
Average age (year)	20.5 (n = 43)	19.4 (n = 39)	19.9 (n = 82, S.D.=1.2)
Average time staying at present address (month)	37.8(n = 44)	30.4 (n = 42)	34.2 (n = 86, S.D.=7.7)
Staying with	Parents = 2Uncle/ aunt = 1 Hostel = 42	Parents = 0Uncle/ aunt = 0 Hostel = 42	Parents = 2Uncle/ aunt = 1Hostel = 84
Stayed at birth place (year)	17.8(n =16)	10.4(n=14)	14.4 (n = 30, S.D. =6.2)
Religion	Muslim = 31 Hindu = 10 Christian = 00 Buddhist = 04	Muslim = 28 Hindu = 10 Christian = 02 Buddhist = 02	Muslim = 59 (68%) Hindu = 20 (23%) Christian = 02 (02%) Buddhist = 06 (07%)
Marital status	Unmarried = 42 Married = 03	Unmarried = 41 Married = 01	Unmarried = 83 (95%) Married = 04 (05%)
Family structure	Extended = 24 Nuclear = 21	Extended = 23 Nuclear = 19	Extended = 47 (54%) Nuclear = 40 (46%)
Average number of siblings	Brothers = 1.8 Sisters = 2.4	Brothers = 1.6 Sisters = 3.1	Brothers = 1.7 (S.D.= 1.2) Sisters = 2.7 (S.D.= 1.3)
Income source of their family	Father's income = 16 Others = 10 More than one income source = 19	Father's income = 23 Others = 11 More than one income source = 04	Father's income = 39 (46%) Others = 21 (27%) More than one income source = 23 (27%)

* The total no. of participants from 3rd and 4th year students was 42 and 45 respectively. But they were not necessarily completed the all parts of the questionnaire because of their personal inconvenience, so the frequency, *n* varies from variables to variables.

In Table 2 shows the attitude and perceptions regarding adolescent sex. Most students (93%) answering the question did not support any relation with young male person and 20% (17 out of 87) agreed that they have boyfriends. Almost all (99%) participants found pre-marital sex to be unacceptable for females, even if the couple planned to get married and an equal proportion responded that even pre-marital sex for boys (young male) was unacceptable. All the participants strongly believed in the importance of a woman to be virgin at marriage. Three out of five students (61%) thought that a woman has to bear the consequences of pre-marital sex in a relationship. There were no significant difference in opinions between 3rd year and 4th year students in this regard.

Table 2, shows, 87 percent respondent agreed that abortion is morally wrong with only minor differences between the two groups (3rd and 4th year student). Only 37 percent respondent agreed with the statement "adolescent abortion is acceptable in case of unplanned pregnancy" with no significant difference between two groups. With regard to contraception, 61 percent of the respondent disagreed to the statement that

unmarried women asking for contraception are "bad girls" and also two out of three respondents disagreed with the statement that Contraceptive information should only be for married couples.

Table 2: Attitudes/perceptions of the participants regarding adolescent sexuality

Statement	Agree n (%)	Disagree n (%)
Support relation with any young male person (Missing, n = 04)	06 (7%)	77 (93%)
Have boyfriend (Missing, n = 33)	17 (31%)	37 (69%)
It is important for a woman to be virgin at marriage (Missing, n = 04)	83 (100%)	00 (00%)
It is wrong to have pre-marital sex (Missing, n = 04)	82 (99%)	01 (01%)
Boys can have pre-marital sex (Missing, n = 11)	01 (01%)	75 (99%)
It is accepted to have pre-marital sex if you plan to get married (Missing, n = 03)	00 (00%)	84 (100%)
Women have to take the consequences from pre-marital sex in a relationship (Missing, n = 05)	50 (61%)	32 (39%)
Abortion is morally wrong (Missing, n = 03)	73 (87%)	11 (13.%)
Adolescent abortion is acceptable in case of unplanned pregnancy (Missing, n = 12)	28 (37%)	47 (63%)
Contraceptive information should only be for married couples (Missing, n = 05)	29 (35%)	53 (65%)
Unmarried women asking for contraceptive use are bad girls (Missing, n = 07)	31 (39%)	49 (61%)

Knowledge of sexually transmitted diseases is measured by the formative answers of the question regarding these. For example, the question "How STDs and HIV/AIDS diseases transmitted?", the students' answers are converted to four scale points such as *(1) know all the causes, (2) know only greater causes, (3) limited knowledge about the infections, and (4) not aware at all,* for the convenience of statistical analysis.

Table 3: Preliminary knowledge assessment of STDs and HIV/AIDS of the participants

Questions	Yes (%)	No (%)
Do you know how a person can get sexually transmitted diseases? (Missing, n = 01)	85 (99%)	01(01%)
Do you know about STDs and HIV/AID (Missing, n = 02)	84 (99%)	01 (01%)
Have you ever had any STDs (Missing n = 03)	00 (00%)	84 (100%)

Although almost all of the students (99%) answered that they know about STDs and HIV/AIDS and also know how a person can get STDs (Table 3), but the answers of the corresponding questions regarding STDs and HIV/AIDS are not satisfactory for almost half of the students (Table 4). The answer of the question "how STDs and HIV/AIDS are transmitted", only 53 percent respondent answered satisfactorily (*the satisfactory answer got by adding the figures of "know all the causes/ways" and "know only greater causes/ways" since there were no statistical significant difference between them*). Surprisingly

no students knew one of the vital causes of these diseases is by drug addicts using same syringe several times. Most of the answers concentrated on unsafe sexual intercourse. This indicates that the lack of total and important factors of knowledge about the way of infection of these diseases. On the same way only 55 percent of respondent answered satisfactorily of the question “do you know how a person can be free from STDs and HIV/AIDS”. Only 41 percent answered satisfactorily the question “how a person can be free from sexually transmitted diseases”. The strangest result came out from the answer of the question “in which ways STDs and HIV/AIDS cannot be transmitted one person to another” was that only one out of five (20%) student answered satisfactorily. Thirty eight of which 85 respondent does not know how a person can be free from sexually transmitted diseases and 12 has a very limited knowledge (table 5).

Table 4: In-depth knowledge about STDs and HIV/AIDS of the students

Questions	*Know all the causes/ways (n)*	*Know only greater causes/ways (n)*	*Limited knowledge about this (n)*	*Not aware at all (n)*
	Answered Satisfactorily		*Answered unsatisfactorily*	
How STDs and HIV/AIDS are transmitted? (Missing, n = 01)	19	27	32	08
	46 (53%)		40 (47%)	
Do you know how a person can be free from STDs, HIV/AIDS? (Missing, n = 01)	19	28	28	11
	47 (55%)		39 (45%)	
In which ways STDs, HIV/AIDS cannot be transmitted one person to another (Missing, n = 02)	13	04	02	66
	17 (20%)		68 (80%)	
How a person can be free from sexually transmitted diseases (Missing, n = 02)	12	23	12	38
	35 (41%)		50 (59%)	

Table 5: Specific knowledge of sexual intercourse interims of HIV/AIDS

Statement	**Agree (n)**	**Disagree (n)**	**Don't know (n)**
Women cannot get infections through sexual intercourse during menstrual cycle			
4th year student	00	32	12
3rd year student	01	22	19
Overall	01	54	31

Missing, *n* = 01 *p*-value = 0.05

Only 16 percent (Table 6) of the respondent agreed that they watch sexually excite pictures/movies or read such type of books/magazines in past but from them only 4 students (30%) watch or read such kind of things in last six months. Average age of the students who watch or read such materials are 17.9 year with S.D. 1.6 year (Table 7) and the average age is lower for 3rd year students. Most of the respondent (9 out of 10) agreed that they collect such materials from their friends and the kinds of things are books or magazines.

Table 6: Information about sexually excite materials

Statement	Agree (n)	Disagree (n)	Not answered (n)
Watch sexually excite pictures/ movies or read such type of books/ magazines (Missing, n = 06)	13	68	06
Watch or read any sexually excite things in last 6 months (Missing, n = 54)	04	29	54

Table 7: Information about sexually excite materials and respondents average age

Statement	Result	
Average age at first see/read sexually excite things (in year)	4th year students	– 18.5 (n=04)
	3rd year students	– 17.5 (n=07)
	Overall	– 17.9 (n=11, S.D.=1.6)
Source of the sexually excited materials	Friends	– 09
	Electronic Media	– 01
	Not answered	– 03
Kind of items that see/read	Books/magazines	– 06
	Others	– 01
	Not answered	- 06

Discussion

This study has been scrutinized the values and attitudes of midwifery students regarding pre-marital sex, adolescent abortion and contraception. It also investigated their knowledge and awareness about the STDs and HIV/AIDS. Some students refused to answer some specific question mainly information about sexually excite materials for their personal inconvenience. Here, from the findings obtained of the study: participant's opinion regarding ethics and culture towards pre-marital sex, its consequences and gender issue in this sense will be analyzed. Finally, implications of these for midwifery education and training will be reflected.

Pre-marital sex, adolescent abortion and contraception are inconceivable for Bangladeshi society and highly moral issues in Bangladesh, as strongly confirmed by this study. Bangladeshi society has severe religious restrictions regarding any premarital sexual relation. Other study supported the idea that religion plays a significant role in the life of individuals in all aspects of the society. Since religion affects the sexual lifestyles of adolescent, religious leaders can play a vital role by mobilizing their members towards supporting HIV/AIDS prevention initiatives in the country[19]. In the questionnaire survey, a majority of the students considered pre-marital sex as morally wrong even if the couple planned to marry. Only few more than one tired of respondents (37%) agreed that abortion is acceptable in case of unplanned pregnancy. Large number of respondents (65%) disagreed with the statement that information about contraception should be used only for married couples. This indicates the changing views about contraceptive use. These findings are similar to another study carried out in Vietnam[2]. However, one study observed that "the reasons given for not using contraceptives at sexual debut and subsequent sexual exposure include unplanned sexual intercourse, fear of side effects, erroneous belief that contraceptives interfere with sexual enjoyment, did not expect to get pregnant, lack of knowledge, and poor access to contraception. This unsafe sexual behaviour frequently results in unwanted pregnancy"[20]. It is observed that early involvement in sexual intercourse indicates an alarming level of vulnerability to STDs and HIV infections among adolescents whose access to proper sex education and health care is frustrated by a network of culture, spatial and socio-economic factors[21]. One-study findings show that "parents are very important in children's sex education because they not only teach facts but also attitudes. But many parents indicate that they lack information and feel uncomfortable communicating with their children about sex"[22].

Gender inequality is now the so-called issues everywhere that is acceptable for Bangladesh also. This criterion was visible in relation to some of the issues brought up in this study. In the survey the

majority (61%) of the respondents felt that young women had to bear the consequences in terms of moral judgment, unwanted pregnancies and abortion. Another important finding of this study was that almost all respondents (99%) stated that it is wrong for a boy/young man to have sex before marriage. We interpret the respondents' disapproval as a reaction against society's dual morality on gender and sexuality. Similar findings were shown in another study[2]. It is well known how gender inequality puts young women in a vulnerable position in sexual relations[23]. Sexual experiences reflect gender disparities. A study outcomes stated that "a considerably larger percentage of adolescent boys than adolescent girls have had pre-marital sex. Male adolescent are more likely than girls to have a one-night stand, and girls are, in contrast, more likely to have had only one partner and are less likely to have used alcohol and drugs during the first sexual encounter"[24]. The midwives roles, ideally, should be to empower their clients to prevent unwanted pregnancies and negotiate safe sexual relationships, rather than to impact their own attitudes[25].

In Bangladesh an urgent need for reproductive health care has emerged especially in urban areas. The new challenge is the sexual and reproductive health of adolescents. This is particularly important for Bangladesh because recent studies suggest that we have on serious risk of STD and HIV/AIDS infections socially and demographically. However, the new challenges and needs do not seem to be reflected in the education program in the institutes where the study was conducted. Respondents found that the program focused mainly on general patients' care including child bearing and care for married women. Their education on adolescent sexuality and reproductive health problems seemed to be focused mainly on warning about risks and dangers. From the answers of the questions regarding STD and HIV/AIDS, it is clear that less concentration was given in their study about these because almost 37 percent answered that they don't know whether women get infections through sexual intercourse during menstrual cycle and no one answered that HIV/AIDS can be transmitted through drug addiction by using same syringe several times even though almost all of them answered that they know about STDs and HIV/AIDS and its way of transmissions. So, this study indicates/suggests that midwifery students need more updated education/information about STDs and HIV/AIDS. The implications for policy and programmes are clear. Health professionals who care for adolescents must be trained in the assessment of social abuse and mental health, communication skills and psychosocial interventions. Interventions aimed at improving reproductive health must address issues such as personal safety and prevention of abuse, mental health detioration and self-esteem, substance abuse and communication skills (e.g. with parents). Gender-sensitive programmes for adolescents are needed, and programmes should focus on teachers and parents.

In the questionnaire there were few qualitative questions which were focused on measuring knowledge of STDs and HIV/AIDS. Therefore, these were quantified by using dummy variables for statistical analysis and inference. e.g. the dummy variable procedure for testing the relation between age of the respondents and their knowledge about transmission way of STDs and HIV/AIDS. It is detected that there is no significance difference in knowledge level and age. "Quantitative attitude scales have well-known limitations for measuring complicated ethical and moral issues"[26], but are useful if one wants to get an overall picture from groups. By combining qualitative and quantitative data it was tried to obtain both a broad, as well as an in-depth view of students' values and attitudes.

Matters of pre-marital sex, adolescent abortion and contraception use before marriage are sensitive issues in Bangladesh. So, one might expect students' answers to be biased towards what is socially acceptable rather than their own personal views. In the survey, the confidentiality of the situation makes any such bias unlikely. Also there is a tendency of respondents to skip answering of some questions frequently such as age, father's income or at least income of their family, their boy friend etc.

Conclusion

Midwives and other health professionals in Bangladesh, responsible for providing all general health care including adolescent sexual and reproductive health, are at a critical point of intersection between society's dominant moral discourse of abstinence before marriage and the reality of a changing youth culture where the consequences of unprotected sex are part of daily experience. The above mentioned ethical dilemmas need to be given more attention in education and training programmes. The findings suggest that more reflective pedagogy and moral reasoning should be included in the Bangladeshi midwifery education. Exposing students to different ethical perspectives in both education programs and clinical practice can enrich their understanding of the complexity of such

issues. This will improve the relationship between health providers and their young clients, and enable them to deal professionally with the complex realities of a rapidly changing attitude of the society.

Therefore, this study recommends that proper sex education and family life education for young people encourage them to delay sexual activity and practice safe sex when it eventually commences. There is also a need to sensitize the young people, parents, teachers, the community and all stake holders on the magnitude of the problem and to open up dialogue that will break the social, cultural and other mysteries hindering adolescent and youth reproductive health education and services in Bangladesh.

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