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Abstract- Adolescence period is a very important transitional stage of human develoment as in this period a human being undergoes some major physical, emotional and social changes. Bangladesh has an adolescent population consisting one fifth of the total population. Among them almost half of them are girls. Among the adolescent girls who belong to the late adolescent age group are in the most exposed and disadvantaged situation in the context of Sexual and Reproductive Health (SRH) of Bangladesh. Therefore, the aim of this article is to concentrate on the SRH of adlescents girls (15-19 years) with an aim to reveal the trends and experieces of SRH among this group and some major challenges so that female adolescent SRH issues can receive proper attention in the policy making level.

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I. Introduction

Adolescence period is a very vital transitional stage of human develoment. According to the World Health Organization (WHO) those persons between 10 and 19 years of age will be considered as adolescent (WHO, 2014). This phase is depicted by as a period of human growth and development that occurs in between the childhood and adulthood. In this stage a human being experinces some physical, emotional and social changes that necessiate understanding and effective approaches to fulfill the particular needs of adolescents. Physically adolescents go through pubertal changes and changes in brain structure. Psychologically adolescents develop cognitive maturity and critical thiniking skills. They also experience social changes due to the multiple roles they are anticipated to play in the family, community and at school. These alterations occur simultaneously but at a different speed depending on their gender, socio-economic, educational background or other structural and environmental factors (UNICEF, 2011).

As an important development stage of human life, adolescene period is further splited into early adolecesncen (10-14) years and late adolescence (15-19) years. Major physical changes usually occur in late adolescence.[1] In late adolescence girls usually are at greater risk than boys of negative health outcomes because of the gender based discrimination and abuse (UNICEF, 2011). Bangladesh has an adolescent population (those between the ages of 10 and 19 years) of around 29.5 million, more than one fifth of the total population, including 14.4 million girls and 15.1 million boys (Ainul, et al., 2017). Among the 14.4 million girls who are belong the the age group of 15-19, are in the most vulnearble and disadvantaged condition in the context of Sexual and Reproductive Health (SRH). They are the major victim of child marriage, early and risky unwanted sexual activity and pregnency, domestic violence and do not receive rapid care which expose them to adverse health outcomes. Child marriage and adolescent prgnency increase the risk of maternal and child morbidity along with maternal and child mortality. Therefore, this article focuses on the SRH of late female adlescents with an aim to expose the trends and experieces of SRH among this group, available and policy issues and challenges so that some necessary interventions and policies can be taken to enusre necessary services, information, skills for maintaining their healthy and productive lives.

II. Socio-Cultural context of Bangladesh in Relation to Sexual and Reproductive Health

In Bangladesh, as girls reach and progress through adolescence, the gendered norms of their socio-cultural surroundings also begin to play an amplified role in shaping their routes. With the years of late adolescence these social norms begin to become both more severely enforced and more personally prominent. Critically for girls in Bangladesh, the years of adolescence, rather than spreading out their worlds, often perceive them made smaller as girls have to leave comparatively free childhoods and are compelled to accept the gendered adult pathways of their own local environments (Presler-Marshall and Stavropoulou, 2017).

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As Bangladesh is a conservative country, the discussion related to sexuality, fertility and pollution is considered a shameful and a hidden subject. Besides the effect of conservatism and strong patriarchal structures, the country is also influenced by Islam, Hinduism, and traditional religious beliefs. In the predominantly customary and traditional Bangladeshi society, young unmarried adolescents girls are expected to be modest and protected from knowledge of sex, sexual experience and reproduction (Khan, et al., 2002). Moral disapprobation of premarital sexual activities means that general discussion and knowledge of such issues usually are very limited. (Rashid, 2000:28). Low levels of education coalesce to create an atmosphere of misunderstanding regarding sexual and reproductive health (Nahar, et al., 2020). Therefore, in the context of Bangladesh, it is difficult to inquire about sexuality or sexual and reproductive health for those who are unmarried because of its intimate characteristic and the aspects or norms of the society prescribe these issues to be kept inaudible and invisible as possible. Consequently, 'understandings of sexuality remain largely heteronormative, in which health rights are thought of in terms of reproduction and family planning between men and women, and information outlets and services continue to cater to married adolescents mostly' (Khan, et al.,2002:598) rather than if they are sexually active.

Moreover, due to the conservatism, negative attitudes towards homosexuals in Bangladesh are still very high. Inheriting from the British Indian Government's section 377 of 1860, homosexuality is not legal under Bangladeshi law and matter of punishment up to life imprisonment (Bangladesh Penal Code, 1860). Therefore, it is precarious for those who identify themselves as homosexuals to openly receive adolescence health services as homosexuals. Sexuality related social stigma and conservative mentality also inhibit to get proper health services for adolescents who engage in sex work or who are children of sex workers. Therefore, as a heterogenous group adolescents are marginalized and vulnerable due to a variety of factors in Bangladesh, especially adolescent girls do not get optimal conditions to develop their full potential and make sure their good health in their transition into adulthood.

III. Trends/Patterns of Sexual and Reproductive Health of Late Female Adolescent

a) *Early Marriage Among Late Female adolescents in Bangladesh*

The number of child marriage is remarkably high in Bangladesh. The median age at marriage for girls in Bangladesh still continues low compared other developing countries. The country ranks among the top ten countries in the world with the highest levels of child marriage. 51% of Bangladeshi girls marry before reaching age 18 and it is the home to 38 million child brides, including currently married girls along with women who were first married in childhood, of these 25 million married between 15-19 years (UNICEF, 2020).

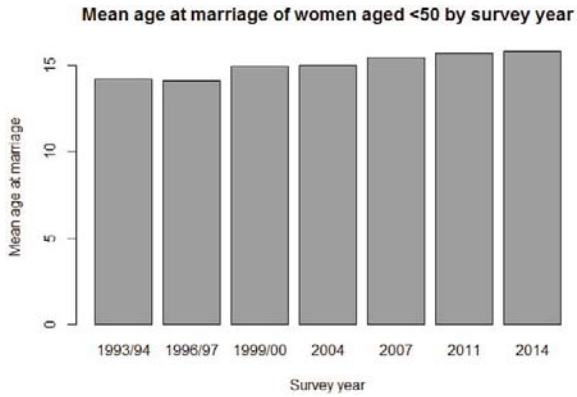

Figure 1

Though the age at marriage is still notably low, an important increase is observed since 2000 due to the factors like women's increasing participation in education, their urban resident and socioeconomic status (Presler-Marshall and Stavropoulou, 2017). According to the first survey carried out in 1993/94, (data shown in the Figure 1) the mean age of women at first marriage was about 14.25 years; it was barely reduced in 1996/97 (about 14.16 years). As 95% of Bangladesh girls experience their first period between 13.5 and 14.5 years of age, therefore, it has been observed that, until 1997, women got married around the age of puberty. A remarkable increase of almost 0.75 years of the mean age at marriage was observed in 1999/2000. It was nearly the same from 1999/2000 to 2004 (about 15 years). Later, it increased about 0.5 year in 200 (Zahangir and Nahar, 2021). This rising trend has been persisted and reached 15.86 years in 2014.This denotes that Bangladesh has been able to make some notable progress in decreasing early marriage.

As adolescent unmarried girls in traditional and conservative Bangladeshi society are highly protected from gaining any knowledge regarding sexual and reproductive health, therefore, at the time of marriage, they have very inadequate knowledge about sex and married life. A study conducted by Khan, et al., reveals that out of the total 54 respondents, 24 (44%) had no previous knowledge about sex before being married. Some participants mentioned that 'just days before their marriage, they were informed either in code words or vaguely about the sexual life' by their sisters-in-law, married friends or some elder female relatives in the family. By doing that they are mainly got ready to submit themselves to the wishes of their husbands (2002:242). This clearly establishes husband's authority on the

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sexual life and reproductive goals of that couples. The Demographic Health survey 2014 found that married adolescent girls aged between 15-19 years were the least compared to all women to be allowed to decide on family planning and reproductive health related decision making (NIPORT et al., 2016).

i. *Causes of Early Marriage in Bangladesh*

In Bangladesh, female's sexual roles are meant to be private and controlled (Khan, et al., 2002). Therefore, the main reason of child marriage is the gendered social norms that emphasizes a great value on female's chastity which is considered as central to family honor. When girls reach puberty, it creates a strong change in parents demand to marry off their daughters. Begum (2003) explains, "In Bangladeshi society a teenage daughter reaching menstruation becomes a burden for many parents because preservation of her virginity is the greatest concern for a bride. As a result … parents like to get their daughters married as early as possible "(p.86). Field and Ambrus, (2008) reported that more than 70% of first marriages occurred within 2 years of menarche in Bangladesh. Another reason of child marriage is poverty. As poorer families do not have the financial ability to invest in substitute options for girls, such as education. Parents see marrying off their daughters as an option to reduce economic hardship by getting rid of this burden through transferring it to her husband's family. In this context, for securing economic and social security, marriage of an adolescent girl, usually to an older man, is seen as a strategy. In addition, dowry which was outlawed in 1985 through "Dowry Prohibition Act", has also an implication for child marriage. The family of the bride has to provide the bridegroom a dowry. Younger brides usually needs smaller amount of dowries. Another important drive of child marriage is originated from the urge to continue male dominance and ensuring female obedience. It is believed by husband and his family that 'at a young age girls are like tender bamboos', therefore they can molded a young girl according to their wishes (Khan, et al., 2002: 242). Consequently, 'girls who have started to aspire to a world different from those of their mothers and their grandmothers find as their bodies evidence maturity that they are too often required to leave school and marry' (Presler-Marshall and Stavropoulou, 2017:1).

Since 1929 child marriage has been unlawful in Bangladesh and Child Marriage Restraint Amendment Ordinance, 1984 has established the minimum age of marriage at 21 for male and 18 for female. However, 'the problem is, in the early 2017s, the government of Bangladesh passed a new law titled "Child Marriage Restraint Act, 2017" that allows 'for child marriage to occur in "special circumstances". That is, with parental consent and with permission from the courts "the best interested of the underage female or male" can be married, while the minimum age at marriage (18 for women and 21 for men) did not change' (Zahangir and Nahar, 2021: 2)". The widely criticized new child marriage law in Bangladesh opens the door for parent to legalize the early marriage of their daughters.

b) *Early Pregnancy, Maternal Care and Maternal Mortality of Adolescent Girls*

Girls who marry at a young age face severe pressure to become pregnant. Therefore, because of the prevalence of child marriage and a continued predilection for childbearing, Bangladesh has the highest rate of adolescent pregnancy in South Asia. According to Bangladesh Demographic Health Survey (2014), 24.6% of 15–19 year old married adolescent have begun child bearing, 1 out of 4 has given birth and another 6 conceived with their first child (NIPORT et al., 2016).

However, despite having a high rate of adolescent pregnancy and childbearing, Figure 2 presents a declining trend in adolescent motherhood in Bangladesh to a slower pace from 1993 to 2014. In 1996–97, 31.0% of 15-19years old adolescent married girls became mothers, which reduced to 27.9% in 2004, and 24.6% in 2014. Lower spousal age gap, women's higher education, wealth level, urban residence and media exposure were found to exert strong affect in postponement in bearing children of among teenage girls in Bangladesh. Adolescent girls in the poorest wealth background were more likely to experience motherhood than the richest wealth level (41% vs 23%). Adolescent girls who had no education were observed to be pregnant or parenting 2.76 times higher odds than those who had higher than secondary education. The prevalence of motherhood among married adolescent girls was consistently lower in urban areas than rural areas. In urban areas, 27% of adolescent girls became mothers whereas 27% of their rural counterparts became mothers. Adolescent girls who had exposure to media were found to have 23.3% lower odds of experiencing motherhood compared to those who did not have media exposure. In addition, married adolescent girls with less than five years of spousal age gap had 55.3% lower risk of motherhood than teenagers with more than 10 years of spousal age gap (Islam, et al., 2017).

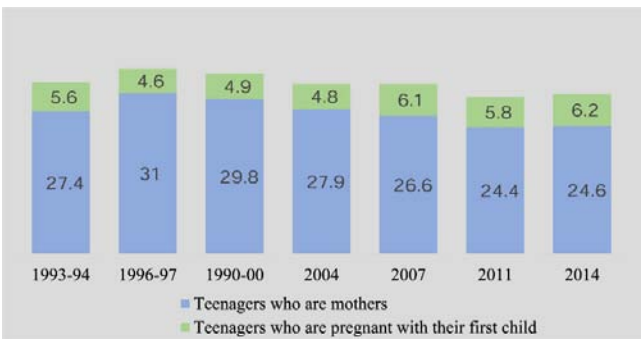

Figure 2

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i. *Causes of Early Childbearing*

A number of factors affect married adolescent girls' capability to delay early childbearing in the social context of Bangladesh. Embedded socio-cultural norms around gender roles, entrenched robustly in community and family contexts, equates a girl's value with her ability to child bearing. Girls perceived stigma related with delaying childbirth results in being seen them as infertile by their husbands, in laws or the larger community has powerful influence over the desire for their early child bearing for proving their fecundity. In addition, attempts to delay childbearing may also generate speculation that the married girl is having an extra-marital affair which threatens her position within the family and leave her open to potential physical and mental abuse by her husband and his family. Moreover, these young, adolescent girls also less likely to involve in family planning because of their lack of knowledge of contraceptives and 'male dominated partner dynamics' which establishes a limit on their ability to control the timing and frequency of childbearing. Besides, they face an inordinate number of barriers to access reproductive facilities within the formal health system including lack of physical or financial access to health services bias of providers and stigma around use of contraceptive (Samandari, et al.,2020).

ii. *Maternal Care in Bangladesh*

However, Maternal care in Bangladesh is comparatively well. Government has made health facilities accessible down to union level. Bangladesh Demographic Health Survey (2018) defines quality antennal care as ' a woman has four or more antenatal care (ANC) visits, of which at least one is with a medically trained provider, and receives all of the basic components of ANC (weight and blood pressure measurements, urine and blood tests, and information on signs of possible complications) at least once'. According to the BDHS 2018 definition, only 18% of women receive quality antenatal care and compared to other age groups, women in the age group 15–24 are most likely to receive antenatal care from a medically trained personnel. 72 percent of women have at least one or more antenatal care visits (NIPORT, 2020:122). Factors like women's education, household wealth, urban-rural residence and access to mass media have a significant positive association with the likelihood of receiving antenatal care from medically trained persons. Besides these factors, husband's education level, working/nor working women, religion (more non-Muslim women than Muslim women seeking assistance) were also found to have an important positive correlation with maternity care service utilization. However, the importance of the public sector as a providing source of antenatal care has declined. The private sector has now become the prominent source of antenatal care both in urban and rural areas. Therefore, quality of antenatal care has become related closely to wealth. Though there is a considerable rise among the poorest adolescent women in care seeking for maternal complications (the use of health facilities almost doubled in 2016), the disparity between the quality of care also observable. 37% of women from the highest wealth level get quality antenatal care, compared with only 7% of women from the lowest wealth level (Ibid).

Though there is a substantial increase in receiving antenatal care services, till now 62% of total deliveries still happen at home and more than 56% deliveries are occurred with the assistance of traditional birth attendants (TBAs) or relatives while medically trained provider conduct only 42% of all births, both at home and in facilities at the national level (NIPORT, 2020). Different factors driven people for preferring home delivery with a TBA. Firstly, due to the existing cultural practices, elder, especially female members of the family see giving birth at home as an age-old custom, hence, put restriction on expectant women for going to hospital. Religious fallacy regarding veiling is also a reason for preferring delivery at home. They think that if a pregnant woman physically opens herself to male doctors, it would be a religious sin. Another important reason for occurring deliveries at home is poverty. Poor people do not have enough money to spend on facility based delivery which requires patients to pay for the hospital facilities, cost of the medicine, transport etc. In addition, fear of increased possibility of having a caesarean delivery instead of attempting a normal vaginal delivery in hospitals and the derelict conditions of the roads and limited transportation facilities are also important reason for preferring home delivery (Sarker, et al., 2016).

iii. *Maternal Mortality*

Bangladesh made a significant progress towards achieving Millennium Development Goals (MDG) 4 and 5. According to Bangladesh Maternal Mortality Survey (BMMS) 2010, between 1990 and 2010, maternal mortality in Bangladesh decreased from 574/100000 to 194/100000 live births. However, the adolescent maternal (15-19 years) mortality rate is still very high (NIPORT, 2020). BMMS-2016 found that 134 adolescent mothers per 100000 live births died as a consequence of complications during pregnancy or delivery (NIPORT, 2018).

Different socio-cultural norms and superstitions still exist in Bangladesh and are creating barriers for achieving healthy and safe motherhood. Many of these customs involve putting restriction on women's consumption of adequate food during pregnancy and the post-natal period. In addition, still most of the women give birth at home and are assisted by traditional birth attendants. The deliveries are occurred in unsafe and unhygienic conditions resulting in

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increased risk of maternal mortality (Sarker, et al., 2016).

Maternal care seeking behavior is also other barriers for ensuring safe motherhood. Almost half of adolescent women have one or more complications such as convulsions, vaginal discharge, obstructed labor etc., during pregnancy but they do not seek treatment for those complications because either they think that the condition is not serious or the treatment for the complication is not necessary, therefore, only one in three seek treatment from a trained provider. Another common cause for not seeking maternal care is economical. More than three-fourths of adolescent mothers with time sensitive complications of convulsions or excessive bleeding either fail to ask for any treatment or seek treatment from an untrained provider because of the high cost of service (Ibid).

c) *Knowledge and use of Family Planning Methods among Late Female Adolescents'*

Bangladesh has proved itself as an extraordinary health performer in the area of maternal and child health regarding family planning. The country contraceptive prevalence rate rose from 8% in 1975 to 62% in 2014. At the beginning, the public sector remained the main source for distribution contraceptive methods for most of the users and government's family planning works were crucial in supplying the methods. The door to door family planning services provided by the country's government's contributed to reduce the total fertility rate from 6.3 births per woman in 1975 to 2.3 births per woman in 2014 (Shahabuddin, 2016). At present, the contraceptive prevalence rate among married female adolescents 15-19 years old are 56%. 51% of married adolescent use modern methods where as only 5% use traditional method. Due to the changing government policies private medical sector has become the major source of contraceptive supply for 64% of married adolescents who use contraception-most of them (61%) rely on pharmacies (NIPORT, 2020).

While only almost half of adolescent married girls aged 15-19 use contraception, this is not because they are lack of knowing regarding contraception as Demographic Health Survey (2014) found that 97% of adolescents married girls knew about contraception. However, though almost every married adolescent girls is aware about contraceptives, but many of them do not have the proper knowledge of using contraceptive (Pachauri and Santhya, 2002). Moreover, after marriage, they often receive incorrect or misleading information from sisters-in-law and neighbors, who become the primary source of their information, about contraceptive methods, especially as related to the risk of infertility, which discourage them from using contraceptives. As Married adolescent girls lack of mobility and less frequent contact of government health workers limit their ability to engage with the health services and the opportunity to remove their misconceptions regarding contraceptive methods, they are unable to make free and informed choices, hence, which results in low use of contraception. The use of low contraception is also most importantly linked to their low decision making autonomy to contraceptive methods use and pregnancy. Their age, a low level of education and financial dependency on husband's or his family put them in a situation where, frequently, their voices are ignored. Therefore, their husbands and mothers-in-law play the role of main decision makers regarding use of contraceptive methods and child bearing and they are expected to bear a child just after their marriage by putting her in a position of less empowered (Deb, et. al, 2011).

However, though 75% of unmarried female adolescents have knowledge about at least one of the three common contraceptive methods (oral pill, condom and emergency contraceptive pill, there is no official data regarding use of contraceptives among them. Demographic Health Survey and other national surveys have mostly excluded this group in terms of use of contraception. This is mainly because of the long held social norm that unmarried people do not engage in sexual relationship before marriage in a conservative country like Bangladesh. Therefore, very little is known about their sexual activity and contraceptive use. A Study by Pachauri and Santhya, (2002) reveals that around 6% of unmarried females were active sexually by age 18.5. This study indicates that a large number of unmarried sexually active adolescents do not use any contraceptive method. This is because they do not feel comfortable buying contraceptives from nearby pharmacies or clinics and see providers to be rude and judgmental (Rob, 2001). That may result in a high number of unsafe abortions as being pregnant before marriage is shameful and stigmatizing for themselves and their families (Espinoza, 2020). This is justified by a study conducted by Ahmed, et, al. (2005) which revealed that' unmarried female adolescents were 35 times as likely as married adolescents to abort (20 vs 733 abortions per 1000 births)' (cited in Espinoza, 2020: 189). Most of the abortions (57%) are assisted by traditional untrained providers and a less than half of the abortion are assisted by biomedical health workers through menstrual regulations as abortion is illegal in Bangladesh (Ibid).

d) *Intimate Partner Violence Against Late Adolescent Girls*

Intimate partner violence against married adolescent girls is very common in Bangladesh and is strongly linked to the low status ascribed to them. Violence is mainly manipulated as a tool for controlling women and various aspects of their lives. (Presler-Marshall and Stavropoulou, 2017). Bangladesh Bureau of Statistics carried out the first national Violence Against

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Women Survey of 12,600 women aged 15 and over in 2011. The survey revealed that 65% of married women experienced physical violence- mostly by their husbands. 42% of married adolescent girls experienced violence by their husbands. They experience different form of violence such as physical, sexual, verbal etc. Women's socio-economic dependency on husband, marital conflict, demand of dowry, disobedience to husband, drug or alcohol addiction of the husband etc., were found as causes of violence against women. A study by Pearson, et al., 2016 showed that Intimate partner violence was also related with the disagreement in fertility intentions within the family and contraceptive use. In this case women experienced fertility pressure and pregnancy coercion from their husbands or in-laws. Due to physical violence married adolescent suffered injuries. Sexually violated women experienced pelvic pain and reproductive tract infections. They also suffered from gynecological problems at the times of pregnancy more than non-abused women (Salam, et al., 2006).

Despite the realization that violence against women may be connected with serious consequences for women's lives, as a patriarchal and robustly hierarchical society, the pervasiveness of violence, especially physical violence is still socially accepted as a norm. Bangladesh Demographic Health Survey (2016) found that an important proportion of adolescent married girls aged 15-19 thought that husbands were justified in beating their wives if they argue with them, neglect the children or go out without informing him. Therefore, often victim do not feel that violence against them is something that is worth reporting. The 2015 Bangladesh Bureau of Statistics survey revealed that 70% of married women and girls who had experienced some form of abuse, never told anyone and less than three percent took legal action. As a women's rights lawyer commented 'society thinks domestic violence is silly violence, that it's something that normally just happens in the family' (Human Rights Watch, 2020:2). Besides this attitude towards the physical violence, sexual abuse or marital rape by husband is not considered as a crime as there is no law against marital rape in Bangladesh. If women married to the perpetrator, in that case forced marital sex will not be considered as rape. The main norm is that once a woman is married, her husband has the exclusive right to unlimited sexual access to his wife (Masoom, 2007). Therefore, these social attitudes, along with other issues, serve to produce even more barriers for victims in reporting the abuse as well as pursuing access to opportunities of legal redress and support.

e) HIV/AIDS and Sexually Transmitted Diseases (STDs)

Among adolescent population in Bangladesh, girls are more exposed to Sexually Transmitted Diseases (STDs) than their male counterparts, including HIV/AIDS. Married adolescent girls early sexual initiation, lack of power, lower ability to negotiate for safe sex, lack of access to contraception, lack of education and sexual violence are mainly responsible for their increasing vulnerability to STDs. Moreover, they do not have knowledge and awareness about STDs which make them more vulnerable to STDs (Hossain, et al. 2014). An UNAIDS Bangladesh study revealed that, only 12.8 percent of adolescents and youth had inclusive knowledge on HIV (cited in MoHFW, 2016). According to Bangladesh Demographic Health Survey (2014) showed that only 12 percent of ever-married adolescents had comprehensive knowledge about HIV/AIDS which further substantiates the low levels of knowledge about SRH issues among adolescents girls. A study by Uddin and Chowdhury (2008) revealed that about half of the adolescent respondents could not accurately recognize a single symptom of STDs and more than half of them could not precisely identify a mode of transmission of STDs.

Lack of knowledge about STDs also observed among adolescent sex workers. A study by Uddin and Chowdhury (2008) showed that only 32% of them had ever heard of AIDS whereas only 11% had knowledge of the transmission of HIV/AIDS by unsafe sex. Economic vulnerability of commercial female adolescent sex workers make them more vulnerable to HIV/AIDS. Their clients are significant sources of spreading HIV/AIDs in Bangladesh. In a survey carried out in Northern part of Bangladesh, more than 88% of sex workers reported having unprotected sex, because of clients' insistence (Garai, 2016).

f) Policy Issues and Challenges

The Government of Bangladesh has started to identify the importance of ensuring adolescent health and has adopted this issue in several of its policies. However, unmarried girls need have not recognized properly in those policies. Adolescent Sexual and Reproductive Health is still viewed as synonymous with family planning, which under the traditional Bangladeshi context is only allowed for married women and couples. As child marriage continues to be an important issue in Bangladesh, the needs of married adolescents girls are mainly prioritized through the policies, programs and interventions (Ainul, et al., 2017). The current five year development plan of the government has no particular guideline for unmarried adolescent girls and their SRH needs and other national policies and programs continue to limit unmarried adolescents access to SRH knowledge, information and services. The systematic marginalization of unmarried adolescents from SRH services make them more vulnerable to health risks and inequitable treatment.

Moreover, other vulnerable groups such as lesbian, gay, bisexual and transgender (LGBTQ) are completely ignored in the recommended measures,

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implementation plans and especially in the section on vulnerable adolescents and adolescent in challenging circumstances of National Strategy for Adolescent Health 2017-2030. Due to the traditional social norms and outlook, LGBTQ adolescent fall outside the current SRH care service system. Therefore, unrecognition of their specific vulnerability will make it more difficult for them to get the access of health services and optimal environment to ensure their overall health in their transition to adulthood.

Because of the social norm, institutional and policy related obstacles, most of the programs that are adolescent-specific do not have a significant focus on SRH. Programs which have included SRH-related components, have given a secondary focus on this issue, included it into other, more socially acceptable gender related programs such as child marriage and gender based violence. Issue (Ainul, et al., 2017). Therefore a recognizable focus on STDs, particularly HIV/AIDS services for adolescent is missing which is attributable to having a low level of knowledge regarding STDs among adolescents. Moreover, The extent of interventions addressing adolescent sexual and reproductive health issues is limited. The interventions are not taken at a large enough scale to produce a critical national response. Most of the interventions or programs maximum covers 8-10 districts. Therefore, these interventions have a little impact on the national level.

Overall, a lack of disaggregated data has also been emerged a key challenge in the evidence about late adolescence girls sexual and reproductive health. This is happens not only because much less research have been conducted on SRH issue, but also female adolescents aged 15-19 in Bangladesh are often grouped with adult women. Therefore, to design and implement strategies to promote late adolescent women's SRH in Bangladesh, it is crucial to focus on more age-specific research for getting more information on adolescent sexuality.

IV. Conclusion

Although the government of Bangladesh is exhibiting a strong commitment to address SRH needs of female later adolescents. However, still there are some big issues which are required to be addressed. In doing so government should focus on more research and including the voice of the adolescent girls in the decision making area so that their needs can be identified properly and they can act as an agent of change.

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