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Original Article

PERCEPTION OF ADOLESCENT GIRLS REGARDING COMMUNICATION ON SEXUAL & REPRODUCTIVE HEALTH WITH MOTHERS

Jannat T[1], Ashikuzzaman M[2], Kabir H[3], Podder Irani SP[4], Islam S[5], Rahman MA[6], Akram A[7]

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Abstract:

Background: *Adolescence is a critical phase marked by rapid physiological and psychological changes, including sexual and reproductive health (SRH) development. In Bangladesh, socio-cultural norms often hinder open discussions on SRH between mothers and daughters, leading to inadequate knowledge and risky behaviours among adolescents.*

Aim of the study: *This study assessed the frequency, nature, and barriers of mother-daughter SRH communication in Bangladesh, focusing on adolescent girls' perceptions.*

Methods: *A descriptive cross-sectional study was conducted from January to December 2022 among 291 adolescent girls (Classes 9–10) selected through purposive sampling from three government girls' high schools in Dhaka. Data were collected through face-to-face interviews using a semi-structured questionnaire, and descriptive and inferential statistical analyses were performed.*

Results: *A total of 291 adolescent girls participated in the study, with most aged 15–16 years (79.4%). Awareness of menarche (93.1%) and menstruation (78.0%) was high; however, knowledge of contraception and sexually transmitted infections (STIs) was limited, with low awareness of condoms (21.0%), combined oral pills (22.0%), and IUCDs (4.8%). Shamefulness (75.6%) and lack of initiation (68.4%) were the most common individual barriers to sexual and reproductive health (SRH) communication, while lack of maternal knowledge (54.0%) and communication skills (54.6%) were key maternal barriers. Traditional norms were the most prominent social barrier (82.1%). Although menstruation was discussed by most respondents (81.4%), discussion on STIs was rare (0.7%). Only 13.7% of mothers provided comprehensive SRH information. Maternal occupation was significantly associated with communication barriers (p = 0.042), and religion was significantly associated with SRH discussion (p = 0.044) and perceived social damage related to high-risk sexual behavior (p = 0.031).*

Conclusion: *Mother–daughter communication on sexual and reproductive health (SRH) among Bangladeshi adolescents is limited and influenced by socio-cultural and maternal factors, indicating the need for improved supportive communication strategies.*

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Keywords:
Adolescent SRH, Mother-daughter communication, Bangladesh, Cultural barriers, Reproductive health

Introduction

Adolescence is a critical transitional phase from childhood to adulthood, characterized by rapid physiological, emotional, and psychological development. The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years, marking a time of substantial growth, including sexual maturation[1]. One of the most

1. Dr. Tasnim Jannat, Research Associate, Department of Clinical, Novus Clinical Research Services Limited, Dhaka, Bangladesh,
2. Dr. Md. Ashikuzzaman, Junior Consultant, Department of General ICU & HDU, Islami Bank Hospital and Cardiac Centre, Mirpur, Dhaka, Bangladesh.
3. Dr. Habiba Kabir, Research Coordinator, Department of Internal Medicine, Bangladesh Medical University, Dhaka, Bangladesh.
4. Dr. Susmita Podder Irani, Study Physician, Department of Childhood Development, Projahnmo Research Foundation, Sylhet, Bangladesh.
5. Sadia Islam, Scientific Officer, Department of Laboratory Medicine, Bangladesh Specialized Hospital PLC, Bangladesh.
6. Md. Ashiqur Rahman, Officer, Department of Laboratory Medicine, Novus Clinical Research Services Limited, Dhaka, Bangladesh.
7. Dr. Arifa Akram, Assistant Professor, Department of Virology, National Institute of Laboratory Medicine & Referral Centre (NILMRC), Dhaka, Bangladesh.

Address of Correspondence: Dr Arifa Akram, Assistant Professor, Department of Virology, National Institute of Laboratory Medicine & Referral Centre (NILMRC), Dhaka. E mail: drbarna43@gmail.com, Mobile: +8801816296249
Orcid id: 0000-0001-8829-9817

significant changes during adolescence is sexual and reproductive development, which plays a crucial role in shaping individuals' future health and well-being[2]. However, this period is also marked by increased sexual exploration and experimentation, often occurring without adequate knowledge of reproductive health issues, available information sources, and healthcare services[3].

Many adolescents engage in risky sexual behaviors—hereafter referred to as high-risk sexual behavior (HRSB)—such as early initiation of sexual activity, multiple sexual partners, unprotected sex, and sexual activity under the influence of alcohol. These behaviors increase adolescents' vulnerability to sexually transmitted infections (STIs) and unintended pregnancies. Parents, particularly mothers, serve as primary educators and play a vital role in mitigating these risks by providing accurate sexual and reproductive health (SRH) information[4]. Effective parent–child communication regarding SRH fosters informed decision-making and safer sexual behaviors among adolescents. However, many adolescents lack strong and stable relationships with their parents, limiting their access to reliable SRH information[5]. Consequently, young people often turn to alternative sources such as peers, media, and schools, which may provide incomplete or inaccurate information.

Cultural and societal norms significantly influence discussions on SRH between parents and children. In many societies, particularly in conservative cultural contexts such as Bangladesh, socio-cultural and religious barriers hinder open discussions about sexual health[6]. Adolescent girls, in particular, face restricted access to SRH education due to traditional gender norms and societal expectations[7]. Studies have shown that positive parental relationships, characterized by closeness, affection, and open communication, are associated with lower rates of HRSB among adolescents[8]. Despite these benefits, many parents remain reluctant to discuss sexual health topics with their children due to discomfort, lack of knowledge, or fear of encouraging early sexual activity[9].

The situation in Bangladesh reflects global concerns, where adolescent SRH remains a major public health issue. Bangladesh has one of the highest rates of child marriage and adolescent pregnancy worldwide. The Bangladesh Demographic and Health Survey (BDHS) 2014 reported that 59% of Bangladeshi females were married before the age of 18, and 31% of married adolescents aged 15–19 years were already mothers or pregnant[10]. Adolescent pregnancy contributes substantially to maternal and infant morbidity and mortality, as younger mothers face greater health risks during childbirth. Improved mother–daughter communication on SRH could enhance knowledge, attitudes, and practices related to reproductive health and help reduce adverse health outcomes[11].

Despite global recognition of the importance of parent–adolescent SRH communication, limited research has explored this issue within the Bangladeshi context, particularly focusing on mother–daughter communication. Evidence from high-income countries suggests that open discussions between parents and adolescents are associated with improved SRH outcomes; however, how these interactions occur in Bangladesh remains insufficiently understood[12]. Given prevailing cultural sensitivities and societal norms, exploring adolescent girls' perceptions of SRH communication with their mothers is essential for developing culturally appropriate interventions. This study aims to assess the frequency, nature, and content of mother–daughter discussions on SRH in Bangladesh, as well as to identify barriers and facilitators to effective communication.

Materials and Methods

Study Design and Setting

This was a descriptive cross-sectional study conducted over a one-year period from January to December 2022. The study took place in three government girls' high schools in Dhaka: Mirpur Girls' Ideal School and College, Mohakhali Model High School, and TNT Adarsha Girls' High School, Mohakhali. Data collection was carried out from September 3 to October 22, 2022, following a structured work schedule involving literature review, protocol development, ethical approval (NIPSOM), questionnaire pre-testing, data processing, and report writing. The schools had classes IX and X, with each section comprising approximately 58–65 students. As the study was conducted only in selected urban government girls' schools in Dhaka, findings may not be generalizable to rural or non-government school settings.

Study Population

The study population comprised adolescent girls enrolled in Classes 9 and 10 at the selected

government girls' high schools. These students were considered relevant for the study based on the research objectives focusing on this age and educational group.

Inclusion Criteria: The study included adolescent girls who met the following criteria: students currently studying in Class 9 or 10, those who were living with their mothers, those present on the school premises during the data collection period, and those who provided written assent to participate in the study.

Exclusion Criteria: Adolescent girls were excluded if they were sick at the time of data collection or if their mothers were deceased or not living with them. These criteria helped to ensure the safety of participants and the relevance of family-related variables.

Sample Size and Sampling Procedure

The required sample size was calculated to be 355 participants using the formula $n= z^2pq / d^2$, which is standard for cross-sectional studies. Although the calculated sample size was 355, only 291 participants were enrolled due to ongoing SSC and pre-test examinations and student absenteeism during data collection. This shortfall may have slightly reduced the study's statistical power to detect weaker associations; however, the achieved sample size remained adequate to identify statistically significant relationships for key study variables. Purposive sampling was applied based on school permission, availability of eligible students, and feasibility within the academic calendar.

Data Collection Procedure

Data were collected through face-to-face interviews using a pretested, semi-structured questionnaire designed to assess adolescent girls' perceptions of communication with their mothers regarding sexual and reproductive health (SRH). The questionnaire included both open-ended and close-ended questions, covering socio-demographic information, topics discussed about SRH, communication barriers, and frequency of discussions. Originally developed in English, the questionnaire was translated into Bangla and pretested among adolescent girls at Bogura Government Girls' High School (excluded from the study population) to ensure clarity and relevance, after which necessary modifications were made. Before data collection began, permission was obtained from the respective school authorities. Written and verbal informed assent was secured from all willing participants. Privacy was strictly maintained throughout the interview process. Each day, completed questionnaires were checked for completeness, consistency, and quality. The data were then compiled, coded, categorized, and edited according to the study objectives and variables, and an analysis plan was prepared accordingly.

Statistical Analysis

Data were analyzed using SPSS version 26 and Microsoft Excel 2020. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize categorical and continuous variables. Communication barriers were operationally defined as individual, maternal, and social factors (e.g., shame, lack of maternal knowledge, and cultural norms) that hindered mother–daughter communication on sexual and reproductive health. These were measured using predefined questionnaire items and analyzed as categorical variables. Inferential analysis was conducted using the Chi-square ($\div^2$) test to examine associations between categorical variables, with a 95% confidence interval and a significance level set at $p < 0.05$. Multivariable analysis was not performed; therefore, potential confounders such as maternal education, family type, and socio-economic status were not adjusted for and are acknowledged as study limitations. Results were presented in tables and graphical formats. Categorical variables were expressed as proportions, and continuous variables as mean ± SD. Data quality was ensured through daily review and systematic coding prior to analysis.

Ethical Consideration

For conducting the study, formal ethical approval was obtained from the Ethical Institutional Review Board (IRB) of the National Institute of Preventive and Social Medicine (NIPSOM) Memo no: NIPSOM/IRB/2017/09. Written assent was obtained from all participating students. Institutional permission from school authorities acted as guardian consent for minor participants, in accordance with IRB guidelines. Participation was voluntary, and confidentiality was ensured throughout the study.

Results:

This cross-sectional study was conducted amongst 291 adolescent daughters to see the perception of the adolescents regarding communication on SRH with mother. The table 1 presents the distribution of

respondents by various socio-demographic characteristics. Most respondents (79.4%) were aged 15-16 years, followed by 13-14 years (14.1%) and 17-18 years (6.5%). The majority (94.8%) were Muslim, while 5.2% were Hindu. A slightly higher proportion of respondents were in Class 10 (58.4%) compared to Class 9 (41.6%). The highest proportion of mothers had secondary education (31.6%), followed by primary education (29.6%), illiteracy (22.3%), higher secondary (11.7%), honors (2.7%), and master's education (2.1%). The majority were housewives (73.5%), while 26.5% were service holders. A greater proportion of families had 3 to 4 members (56%) compared to 5 or more members (44%). Nuclear families were predominant (83.5%), with joint families at 16.5% (Table I).

Table IIa shows that major individual barriers to SRH communication included shamefulness (75.6%) and lack of initiation (68.4%). Maternal barriers were also prominent, particularly lack of maternal knowledge (54.0%) and limited communication skills (54.6%), while maternal busyness was reported by 37.8% of respondents. These findings indicate that both adolescent-related and maternal factors substantially hinder mother–daughter SRH discussions.

Table IIb demonstrates that traditional norms were the most influential social barrier to SRH communication, reported by 82.1% of respondents. Cultural taboos were identified by 43.6%, whereas religion was perceived as a barrier by a smaller proportion of respondents (13.4%), suggesting that cultural traditions play a greater role than religion in limiting SRH discussions.

Table IIIa presents respondents' knowledge regarding puberty, menstruation, and related physical, physiological, and social changes. Most respondents were aware of the onset of menarche (93.1%) and recognized menstruation as a normal physiological process (78.0%). Knowledge about physical changes such as increased height (70.4%) and growth of axillary and pubic hair (58.8%) was moderate. Awareness of physiological changes, including mood changes (59.8%) and feelings of shyness (57.4%), was also moderate. Socially, a higher proportion of adolescents reported staying at home during puberty (64.6%), while fewer reported going out with friends (23.7%). More than half of the respondents understood the relationship between menstruation and pregnancy (58.1%) and the importance of maintaining special hygiene during menstruation (75.6%).

Table IIIb summarizes respondents' knowledge of contraceptive methods, sexually transmitted infections (STIs), routes of STI transmission, and high-risk sexual behaviors. Overall awareness of modern contraceptive

Table-I

Socio-demographic characteristics of the respondents

Variables	Characteristics	Frequency (n)	Percent (%)
Age group	13-14	41	14.1
	15-16	231	79.4
	17-18	19	6.5
Religion	Muslim	276	94.8
	Hindu	15	5.2
Class	Class 9	121	41.6
	Class 10	170	58.4
Mother's educational level	Illiterate	65	22.3
	Primary	86	29.6
	Secondary	92	31.6
	Higher Secondary	34	11.7
	Honors	8	2.7
	Masters	6	2.1
Mothers' occupation	Housewife	214	73.5
	Service Holder	77	26.5
Family member	3 to 4	163	56.0
	5 or more	128	44.0
Family type	Nuclear	243	83.5
	Joint	48	16.5

Table-IIa

Individual and Maternal Barriers to SRH Communication (n = 291)

Factors	Response	Frequency (n)	Percent (%)
• Individual factors			
Lack of initiation	Strongly agree	54	18.6
	Agree	145	49.8
	Disagree	80	27.5
	Strongly disagree	12	4.1
Shamefulness	Strongly agree	88	30.2
	Agree	132	45.4
	Disagree	43	14.8
	Strongly disagree	28	9.6
Embarrassment	Strongly agree	36	12.4
	Agree	92	31.6
	Disagree	127	43.6
	Strongly disagree	36	12.4
Perceived negative impact	Strongly agree	24	8.2
	Agree	68	23.4
	Disagree	119	40.9
	Strongly disagree	80	27.5
.	Maternal factors		
Lack of communication skills	Strongly agree	39	13.4
	Agree	120	41.2
	Disagree	98	33.7
	Strongly disagree	34	11.7
Maternal busyness	Strongly agree	23	7.9
	Agree	87	29.9
	Disagree	130	44.7
	Strongly disagree	51	17.5
Lack of maternal knowledge	Strongly agree	32	11.0
	Agree	125	43.0
	Disagree	89	30.6
	Strongly disagree	45	15.5

Table-IIb

Social Barriers to SRH Communication (n = 291)

Social factors	Response	Frequency (n)	Percent (%)
Religion	Strongly agree	11	3.8
	Agree	28	9.6
	Disagree	145	49.8
	Strongly disagree	107	36.8
Tradition	Strongly agree	67	23.0
	Agree	172	59.1
	Disagree	35	12.0
	Strongly disagree	17	5.8
Cultural taboo	Strongly agree	24	8.2
	Agree	103	35.4
	Disagree	114	39.2
	Strongly disagree	50	17.2

Table-IIIa

Knowledge of Respondents on Puberty, Menstruation, and Related Changes (n = 291)

Domain	Variable	Response	Frequency (n)	Percent (%)
Puberty-related knowledge	Starting menarche	Yes	271	93.1
		No	20	6.9
	Puberty starts above 15 years	Yes	37	12.7
		No	254	87.3
Physical changes	Getting taller	Yes	205	70.4
		No	86	29.6
	Breast & buttock growth	Yes	162	55.7
		No	129	44.3
	Menstruation	Yes	227	78.0
		No	64	22.0
	Axillary & pubic hair growth	Yes	171	58.8
		No	120	41.2
Physiological changes	Mood changes	Yes	174	59.8
		No	117	40.2
	Feeling shy	Yes	167	57.4
		No	124	42.6
Social changes	Staying at home	Yes	188	64.6
		No	103	35.4
	Going out with friends	Yes	69	23.7
		No	222	76.3
Menstruation-related knowledge	Related to pregnancy	Yes	169	58.1
		No	122	41.9
	Special hygiene required	Yes	220	75.6
		No	71	24.4

Table-IIIb

Knowledge of Respondents on Contraception, STIs, and HRSB (n = 291)

Domain	Variable	Response	Frequency (n)	Percent (%)
Contraceptive methods	Emergency pill	Yes	55	18.9
		No	236	81.1
	Combined oral pill	Yes	64	22.0
		No	227	78.0
	Condom	Yes	61	21.0
		No	230	79.0
	IUCD	Yes	14	4.8
		No	277	95.2
STI awareness	HIV/AIDS	Yes	133	45.7
		No	158	54.3
	Syphilis	Yes	17	5.8
		No	274	94.2
	Gonorrhea	Yes	13	4.5
		No	278	95.5
STI transmission routes	Sexual contact without condom	Yes	76	26.1
		No	215	73.9
	Blood transfusion	Yes	101	34.7
		No	190	65.3
	Mother-to-child	Yes	88	30.2
		No	203	69.8
High-risk sexual behavior	Unprotected intercourse	Yes	117	40.2
		No	174	59.8
	Adolescent pregnancy	Yes	88	30.2
		No	203	69.8

methods was low, with limited knowledge of combined oral pills (22.0%), condoms (21.0%), and IUCDs (4.8%). Awareness of STIs was also limited; although HIV/AIDS was recognized by 45.7% of respondents, knowledge of other STIs such as syphilis (5.8%) and gonorrhea (4.5%) was very low. Knowledge regarding routes of STI transmission was inadequate, with only 26.1% identifying unprotected sexual intercourse and 34.7% recognizing blood transfusion as transmission routes. Awareness of high-risk sexual behaviors, including unprotected intercourse (40.2%) and adolescent pregnancy (30.2%), remained suboptimal.

Visual representation of respondents and the SRH topics discussed with their mothers, most proportion of the respondents 81.4% were discussed about menstrustion with their mother. 15.8% of the respondents discussed about pubertal changes, 2.1% of them discussed about function of reproductive organ and only 0.7% of the respondents discussed about STI with their mother in Figure1.

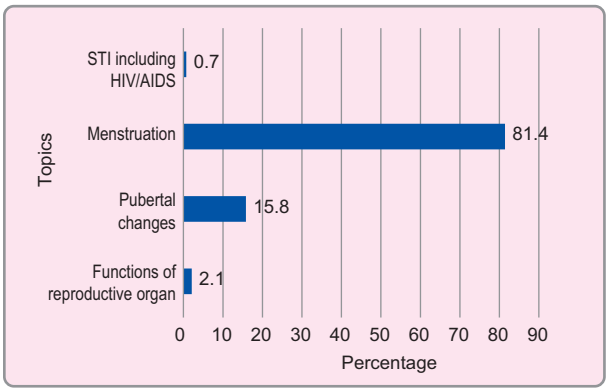

Figure 1: *Distribution of the respondents according to discussed topics with mother*

The figure 2 illustrates how often SRH discussions take place, emphasizing that discussions are infrequent for most respondents.

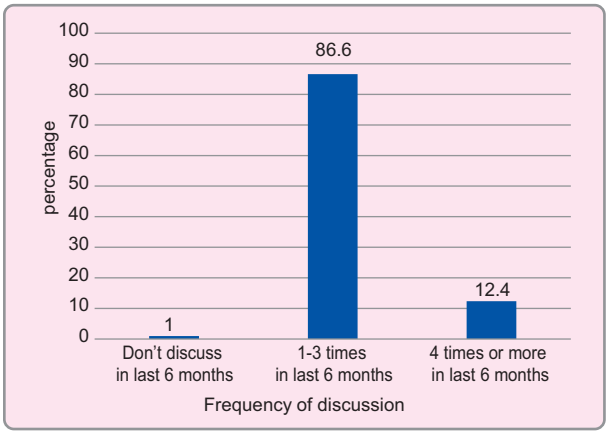

Figure 2: *Distribution of the respondents according to frequency of discussion with mother*

A majority (59.8%) first discussed SRH topics with their mothers when they started menstruation. Only 13.4% had discussions at ages 9-12, while 7.6% had discussions in high school. Notably, 19.2% had never started such discussions (Table 4).

Table-IV

Distribution of the respondents according to their timing of the first SRH related discussion with their mother (n=291)

When first time	Frequency (n)	Percent (%)
When I was 9-12 years	39	13.4
When I started menstruation	174	59.8
When I was in high school	22	7.6
Not started yet	56	19.2

Only 13.7% of mothers provided full information on SRH topics. More than half (51.5%) provided only the information they deemed necessary. Some mothers were unwilling to answer questions (7.6%) or did not allow questions at all (4.8%). 22.3% of mothers provided no response at all. (Table 5).

Table-V

Distribution of the respondents according to their pattern of discussion with mother on SRH (n=291)

How does mother discuss about	Frequency (n)	Percent (%)
Give the full information	40	13.7
Give the only information she thinks necessary	150	51.5
Not wailing to answer the question	22	7.6
Not allowed to ask question	14	4.8
No response at all	65	22.3

Table VI shows a statistically significant association between mothers' occupation and SRH communication barriers, with service-holder mothers reporting fewer barriers compared to housewives (p = 0.042). Religion was also significantly associated with discussion on SRH, where Muslim respondents were less likely to report SRH discussions with their mothers compared to Hindu respondents (p = 0.044). Additionally, perceived social damage related to high-risk sexual behavior differed significantly by religion (p = 0.031). The association between academic class and SRH communication was marginal and did not reach statistical significance (p = 0.054).

Table-VI

Association of respondent's mothers' sociodemographic character with the communication barrier in mother-daughter communication on SRH discussion.

Variable	Category	Communication Barrier Present n (%)	Communication Barrier Absent n (%)	χ^2	df	p-value
Mother's occupation	Housewife	116 (54.2)	98 (45.8)	4.121	1	0.042
	Service holder	52 (67.5)	25 (32.5)			
Religion	Muslim	189 (68.5)	87 (31.5)	0.022	1	0.044
	Hindu	6 (40.0)	9 (60.0)			
Religion (HRSB related to perceived social damage)	Muslim	66 (23.9)	210 (76.1)	0.027	1	0.031
	Hindu	0 (0.0)	15 (100.0)			
Class	Class 9	39 (32.2)	82 (67.8)	0.816	1	0.054
	Class 10	57 (33.5)	113 (66.5)			

Discussion

This study provides important insights into mother–daughter communication on sexual and reproductive health (SRH) among adolescent girls in an urban Bangladeshi context, highlighting the influence of socio-demographic characteristics, individual perceptions, maternal attributes, and socio-cultural norms. The majority of respondents were aged 15–16 years, predominantly Muslim, and from nuclear families, which is consistent with demographic patterns reported in previous Bangladeshi studies[13]. Adolescents living in nuclear family settings may have fewer opportunities for broader family-based discussions on SRH, potentially increasing reliance on maternal communication alone. Furthermore, the relatively low educational attainment of many mothers, with most having primary or secondary education, may limit their confidence and capacity to discuss SRH topics comprehensively with their daughters[14].

The findings demonstrate that multiple individual-level barriers restrict SRH communication. Feelings of shame and lack of initiation were the most prominent obstacles, reflecting deep-rooted cultural norms that discourage adolescent girls from openly discussing sexual matters. Similar observations have been reported in Bangladeshi studies, where embarrassment and fear of social judgment prevented adolescents from initiating SRH-related conversations[15]. The perception among some respondents that SRH discussions could have negative consequences further underscores the persistence of stigma surrounding adolescent sexuality in conservative social environments.

Maternal factors also emerged as significant constraints on effective communication. More than half of the respondents perceived a lack of maternal knowledge as a barrier, alongside limited communication skills and maternal busyness. These findings are consistent with previous research indicating that many Bangladeshi mothers have limited exposure to formal SRH education and therefore feel unprepared to address sensitive topics with their daughters[16]. This suggests that improving maternal knowledge and communication skills may be a critical entry point for strengthening adolescent SRH education within families.

Social and cultural norms were identified as the strongest barriers to SRH communication, with a large proportion of respondents reporting that traditional values and cultural taboos restricted open discussion. This finding aligns with earlier studies from Bangladesh and neighboring South Asian contexts, which have highlighted how societal expectations regarding female modesty and sexuality limit adolescent girls' access to accurate SRH information[17]. Although religion was reported as a less prominent barrier compared to tradition, its influence should be interpreted cautiously. Rather than religion itself, culturally mediated interpretations of religious norms may shape attitudes toward SRH communication, as suggested by previous regional studies[18].

Despite relatively high awareness of menstruation, menarche, and general pubertal changes, knowledge

regarding contraception and sexually transmitted infections (STIs) was notably limited. Awareness of modern contraceptive methods and STI prevention remained low, which is consistent with findings from other Bangladeshi studies reporting inadequate coverage of these topics in family and school-based education[19]. The predominance of menstruation as the primary SRH topic discussed with mothers, contrasted with minimal discussion of STIs, highlights a narrow and reactive approach to SRH communication that focuses on immediate physical changes rather than broader reproductive health risks.

The delayed timing of SRH discussions further illustrates gaps in preventive communication. Most respondents reported that conversations with their mothers began only after the onset of menstruation, with few receiving information before puberty. This pattern has been observed in other Bangladeshi studies and may reduce the effectiveness of SRH education by limiting adolescents' preparedness for pubertal and sexual health challenges[13]. Early, age-appropriate communication has been shown to improve SRH knowledge and protective behaviors, suggesting the need for earlier engagement.

The association between maternal occupation and communication barriers indicates that service-holder mothers may experience fewer constraints in discussing SRH with their daughters. Employment may increase exposure to health information and enhance autonomy, facilitating more open communication[19]. Differences observed by religious affiliation should be interpreted within the broader socio-cultural context and not as inherent religious effects. Similar findings have been reported in Muslim-majority societies, where conservative social norms may influence communication patterns, emphasizing the need for culturally sensitive interventions[20].

The findings underscore the need for integrated policy and programmatic responses to improve adolescent SRH communication in Bangladesh. School-based comprehensive sexuality education, combined with maternal education and communication-skills training, could help address both knowledge gaps and socio-cultural barriers. Community-based awareness programs that engage parents and address cultural taboos may further support the creation of a more enabling environment for open SRH discussions. Strengthening mother–daughter communication has the potential to improve adolescents' SRH knowledge, reduce risky behaviors, and contribute to better reproductive health outcomes.

Conclusion

Adolescent girls are a vulnerable population, making sexual and reproductive health (SRH) communication essential for their healthy development. This study found that mother–daughter communication on SRH in Bangladesh is limited, infrequent, and often delayed, with discussions largely confined to menstruation. Key barriers included embarrassment, lack of initiation, limited maternal knowledge and communication skills, and prevailing socio-cultural taboos. Mothers commonly provided selective rather than comprehensive SRH information. These findings highlight the need for strategies that promote open, timely, and informed SRH communication between mothers and adolescent girls to improve reproductive health outcomes.

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Limitations of the study

Several limitations existed in this study. These are started below:

- Due to purposive sampling technique selection bias may be present during data collection.
- Due to SSC examination and pre-test examination estimated sample size was difficult to achieve, after considering the sample size and existing situation during the study high effort was given to collect the sample size as close as possible.
- This study was conducted only in selected girls high school in Dhaka city. So that would be difficult to generalize the result in the context of all adolescent girls of Bangladesh

Conflict of interest: None declared

Ethical approval: Approved by IRB, NIPSOM, Mohakhali, Dhaka

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