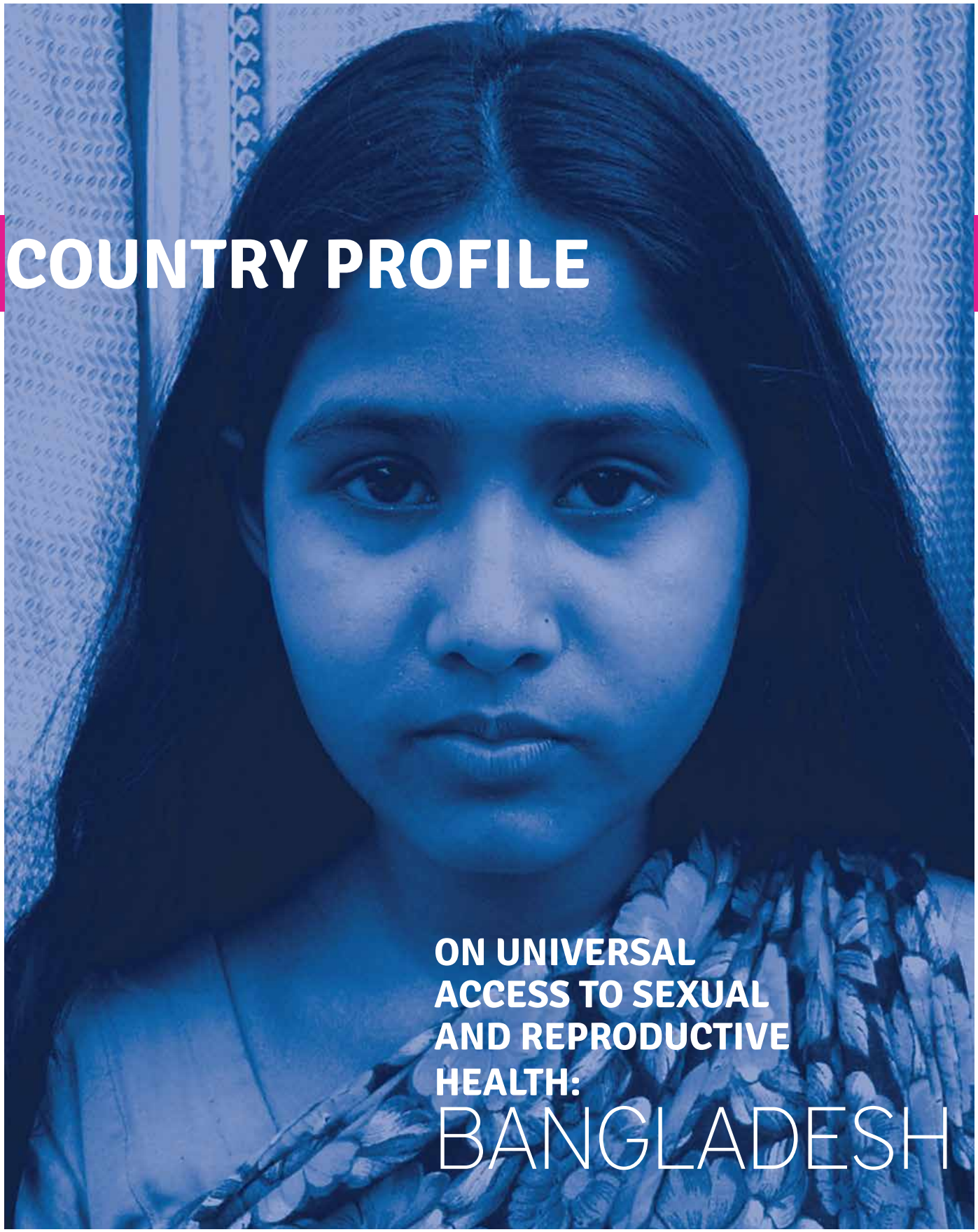

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH: BANGLADESH

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Contents

Acronyms

ABR	Adolescent Birth Rate
ANC	Antenatal Care
ARVs	Antiretroviral Drugs
ART	Antiretroviral Therapy
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic Health Survey
CSBA	Community Skilled Birth Attendant
CEmOC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CBO	Community Based Organizations
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CMW	International Convention on the Rights of all Migrant Workers and Members of Their families
CRC	Convention on the Rights of Children
CBD	Community Based Distribution
DHS	Demographic Health Survey
EmOC	Emergency Obstetric Care
FWV	Family Welfare Visitor
GDP	Gross Domestic Product
GK	Gonoshasthaya Kendra
GEH	Government Expenditure on Health
HASAB	HIV/AIDS and STD Alliance Bangladesh
IMR	Infant Mortality Rate
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
ICPD	International Conference on Population and Development
ICCPR	International Covenant on Civil and Political Rights
IUDs	Intrauterine Devices
MDG	Millennium Development Goal
MIS	Management Information System
MCWCs	Mother and Child Welfare Centres
MMR	Maternal Mortality Rate
NGOs	Non Government Organizations
NASP	National AIDS/STD Programme
OTH	Optical Transport Hierarchy
PMR	Perinatal Mortality Rate
PHC	Primary Health Care
PWUD	Persons Who Use Drugs
RTC	Regional Training Centre
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
ICESCR	International Covenant on Economic, Social and Cultural Rights
BMMS	Bangladesh Maternal Mortality Survey
TFR	Total Fertility Rate
THE	Total Health Expenditure
TTBAs	Trained Traditional Birth Attendants
UH &FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WHRAP	Women's Health and Rights Advocacy Partnership

1. Introduction

According to the Population and Housing Census (PHC) 2011, Bangladesh is one of the most densely populated countries in the world with a total population of 149.8 million. The population density is about 1015 persons per square kilometre (BBS 2012). Ensuring health services for the population is difficult but the government is striving to extend its reach to everyone. Bangladesh is currently spending 3.7 (4.0) percent of its GDP on the health sector. The total health expenditure as percentage of GDP remained at 4 percent (3.7 percent) in 2012. The General Government Expenditure on Health (GGHE) as percentage of Total Health Expenditure (THE) declined over the years to 34 percent (compared to 36 percent in 1995). Proportionately, the private expenditure on health increased to 66 percent in 2012. The out of pocket expenditure as percentage of Total Health Expenditure (THE) also increased over the years to 63 percent, which means that a significant share of the health expenditure is being borne by the people and care seekers.

When women are the care-seekers, they face some additional barriers compared to men. These barriers include those generated by unequal gender power relations and women's subordinate status in the family and society, such as lack of allocation of funds for the female members of the household who may not be earning and whose health is not the top priority in the household. Only 12.9 percent of women take their own decisions regarding their health (BDHS 2011). Women also face barriers to accessing health care related to sexual and reproductive issues. Adolescents are a specific group who face problems in accessing SRH associated care and information. Often they are faced with legal barriers such as parental consent or age limits to access information and services. In addition to this, their access and rights to services are more often than not hindered by people's perceptions and attitudes towards them as service users, where judgemental attitudes prevent adolescents from seeking services on SRH.

With respect to Human Rights covenants, treaties, and conventions, Bangladesh has acceded to the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Bangladesh ratified CEDAW on 6 November 1984, with reservations on Articles 2,[1] 13, and 16.1 (c) and (f)[2]. Subsequently reservations on Articles 13 and 16.1 (f) were withdrawn. Bangladesh is also a signatory to CRC and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW).[II] Bangladesh adopted the 1994 Programme of Action of the International Conference on Population and Development (ICPD), along with 178 other countries and the Beijing Platform of Action in 1995 along with 188 other countries.

2. The status of sexual and reproductive health services in Bangladesh

Bangladesh is among those countries that are working to achieve the MDG goals: MDG 4 (Reduce Child Mortality), MDG 5 (Improve Maternal Health) and MDG 6 (Combat Major Diseases). In this regard, Bangladesh has made significant achievements which are the results of joint efforts by the Government and other non-government stakeholders. To understand the sexual and reproductive health status of Bangladesh we will discuss some related issues.

2.1 Maternal Mortality:

According to the country's first MDG Progress Report, the maternal mortality ratio in 1990 was 574 per 100,000 live births in Bangladesh. However, according to Bangladesh Maternal Mortality Survey (BMMS), maternal mortality declined from 322 in 2001 to 194 in 2010, a 40 percent decline in nine years.

The average rate of decline from the base year has been about 3.3 percent per year, compared to the average annual rate of reduction of 3.0 percent required for achieving the MDG in 2015. The BMMS 2001 and 2010 show that overall mortality among women in the reproductive ages has consistently declined during these nine years[iii]. The Maternal Mortality Estimation Inter-Agency Group (MMEIG) found the MMR to be 170 in 2013.

2.2 Contraception

The ICPD Programme of Action stated that people should be able to have a satisfying and safe sex life and the capability to reproduce and the freedom to decide if, when and how often to do so. The programme of action reiterated the rights of men

and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice[iv]. "The right to decide the number and spacing of children is enshrined in international agreements, and provision of contraception is critical to achieving this right.

Since ICPD in 1994, there has been significant improvements on indicators related to contraception, particularly with respect to the Total Fertility Rate (TFR), Contraceptive Prevalence Rate (CPR) and Unmet Need for Contraception in Bangladesh (see Table 1.1).

Table 1 : Contraception Indicators in Bangladesh

	Bangladesh				Data Source
	1994-1996	2003-2005	2011	2014	
Total Fertility Rate	3.4	3	2.3	2.3	BDHS
Contraceptive Prevalence Rate	44.9	58.5	61.2	62.4	BDHS
Unmet Need for Contraception	21.6	15	13.5	12	BDHS

In this section we look at key indicators namely a) Total Fertility Rate (TFR), which is an indicator of good or poor reproductive health since a high fertility rate (> 5 births) represents a high risk of reproductive ill health; b) Contraceptive Prevalence Rate (CPR), which is a proxy measure of access to reproductive health services, by assuming there is no coercion for acceptance of birth control through government policy or by indicating access to range of contraceptive methods regarding its distribution and male responsibility in use of contraceptives; c) Unmet Need for Contraception, which is also a proxy indicator of access to reproductive health services[v].

The TFR and Unmet Need for Contraception has decreased over time whereas the CPR has increased. Nevertheless, 12 percent of currently married women have an unmet need of FP services.

Both modern and traditional methods are practiced in Bangladesh. The burden of contraceptive use falls mostly on women.

2.3 Total Fertility Rate (TFR):

According to the BDHS (2014), early childbearing is quite common in Bangladesh with almost half of the women giving birth by age 18 and almost 70 percent by age 20. There has been a decline in fertility from 3.4 births per woman in 1993-94 to 2.3 births per woman in 2014. The total fertility in rural areas (2.4 births per woman) is higher than in urban areas (2.0 births per woman). Total fertility is also associated with education, with 2.9 births per woman with no education compared to 1.9 births per woman among those with secondary or higher education. We also notice a negative correlation of births with wealth. The number of women in highest wealth quintile having more than one child is less than women in the lowest wealth quintile[vi]. The above pattern shows women in higher wealth quintiles with higher education and in urban areas are more likely to exercise their fertility choices.

2.4 Unmet need for Contraception

About 12 percent of currently married women in Bangladesh have an unmet need for contraception, with 7 percent for limiting and 5 percent for spacing of births. Women in rural areas have a higher unmet need for contraception (12.9 percent) compared to women in urban areas (9.6 percent). Further examination of data show women in the age group of 15-19 have a higher unmet need for contraception (17.1 percent), compared to all other age groups, and the pattern shows a decrease in the unmet need with increasing age. The association between unmet need for family planning and freedom of choice of contraceptives was highly significant ($p=0.001$)[vii].

2.5 Contraceptive Prevalence Rate (CPR)

From the national demographic survey (BDHS 2014) we can see that 62.4 percent of women in Bangladesh use some form of contraception, with more than half (54.1 percent) of the women using modern methods

of contraception. Among modern methods, the use of the oral pill is high at 27 percent, followed by injectables (12.4 percent), male condoms (6.4 percent) and female sterilisation (4.6 percent).

8.4 percent of the women use traditional methods of contraception, and 6.2 percent of couples rely on periodic abstinence.

Table 2 : Distribution of contraceptive burdens

Age	Any method	Any Modern method	Female sterilisation	Male sterilisation	Pill	IUD	Inject-ables	Im-plants	Male Condom	Any traditional Method	Periodic abstinence	Withdrawal	Other
15-49	662.4	54.1	4.6	1.2	27	0.6	12.4	1.7	4.6	8.4	6.2	1.9	0.3

Source: BDHS 2014

2.6 Maternal Health

The ICPD Programme of Action called for the promotion of women's health and safe motherhood by achieving a rapid and substantial reduction in maternal morbidity and mortality as well as greatly reducing the number of deaths and morbidity from unsafe abortions[viii].

In this section we look at key indicators pertaining to the promotion of women's health:

a) Maternal Mortality Ratio (MMR), which is a reflection of how safe child delivery is for the woman;
b) Perinatal Mortality Rate (PMR), which is a good indicator of both status of maternal health and nutrition as well as quality of obstetric care;
c) Infant Mortality Rate (IMR) which is also a reflection of optimal maternal health, nutrition and care during delivery;
d) Proportion of births attended by skilled birth attendants, which helps convey the extent to which governments have invested in developing human resources necessary for ensuring safe delivery and prevention of maternal deaths;
e) Availability of basic emergency obstetric care and comprehensive emergency obstetric care to ensure safe delivery and prevention of maternal deaths; and
f) Antenatal Care (ANC) coverage which is an indicator of women's access to health care services.

2.7 Maternal Mortality Ratio (MMR)

The overall Maternal Mortality Ratio has decreased since 1994. BMMS 2010 showed that the ratio has come down to 194 per 100,000 live births from 560 per 100,000 live births in 1994. Various health and population policies and government strategies contributed to this decrease in the rate[ix].

In 2010, Haemorrhage and Eclampsia remained the major causes of maternal deaths, accounting for more than half of those deaths in Bangladesh. Unsafe abortions have contributed to 1 percent of the deaths, which is a decline from the 5 percent in 2001[x].

Figure 1 Causes of Maternal Death

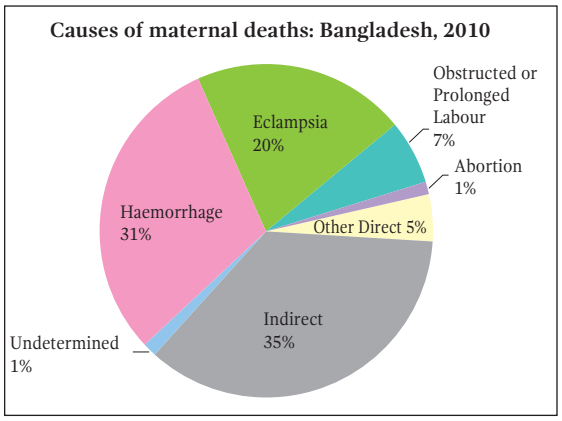
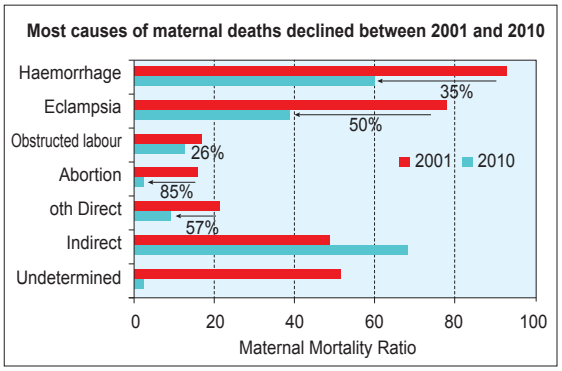


Figure 2 Decline of causes of maternal death



The Safe Motherhood Campaign was initiated by Naripokkho in Bangladesh, and afterwards, in 1998, was taken up by the Government in collaboration with UNICEF. Since then the International Day of Action for Women's Health has been celebrated in the country as Safe Motherhood Day, to create awareness about safe delivery and positive birth outcomes.

Another initiative contributing to the decline in Maternal Mortality Ratio has been the increased access to EmOC services, which are now available at district level for all and in some sub-district level facilities as well. The Women Friendly Hospital Initiative of the Government, implemented in 25 District Hospitals and 4 *Upazilla* Health Complexes facilitated by Naripokkho and supported by UNICEF, has made a positive contribution to the health system by increasing availability of 24-hour EmOC services.

In Bangladesh, till now, 62 percent (BDHS 2014) of births take place at home, and 43 percent (BDHS 2014) of births are attended by medically trained professionals since EmOC & SBA services have increased, due to direct intervention of Government and NGOs. Proportion of use of skilled attendants at birth has increased to 43 percent in 2014 compared to 16 percent in 2004. Nevertheless, other data sources (Trends in Maternal Mortality) show that the ratio is higher (240 instead of 194).

According to Bangladesh Maternal Mortality Survey (BMMS), maternal mortality declined from 322 in 2001 to 194 in 2010, a 40 percent decline in nine years. The average rate of decline from the base year has been about 3.3 percent per year, compared with the average annual rate of reduction of 3.0 percent required for achieving the MDG in 2015. The BMMS 2001 and 2010 show that overall mortality among women in the reproductive ages has consistently declined during these nine years. The Maternal Mortality Estimation Inter-agency Group (MMEIG), however, found the MMR as 170 per 100,000 live births in 2013. The overall proportion of births attended by skilled health personnel increased by more than eight-folds in the last two decades, from 5.0 percent in 1991 to 42.1 percent in 2014. During the same period the antenatal care coverage (at least one visit) has increased 51 percentage points; 27.5 percent in 1993-94 to 78.6 percent in 2014 (MDGs Progress Report 2015 Bangladesh).

Although 22 percent of the births were delivered in a private facility, only 13 percent were delivered in a public facility, and 62 percent delivered at home. The likelihood of delivering in a health facility is lower for women age 35 or older compared with those who are younger. Facility delivery decreases sharply as birth order increases. On the other hand, the numbers of antenatal care visits, education level, and wealth status have a positive relationship with the likelihood of delivering in a health facility (BDHS 2014).

Obstetric care from a trained provider during delivery is critical for the reduction of Maternal and Neonatal Mortality. Four in ten births (42 percent) in the three years preceding the survey were attended by medically trained personnel, that is, a qualified doctor; nurse or midwife; family welfare visitor (FWV); or community skilled birth attendant (CSBA). Another four in ten births (38 percent) were assisted by dais or untrained traditional birth attendants, 10 percent by trained traditional birth attendants and 7 percent by relatives and friends. The proportion of deliveries by medically trained providers doubled from 16 percent in 2004 to 32 percent in 2011, and has increased to 42 percent in 2014 (BDHS 2014).

Of the total maternal deaths, 59 percent are due to direct obstetric causes: 31 percent haemorrhage, 20 percent due to eclampsia, 7 percent due to prolonged labour, 1 percent unsafe abortion and 17 percent due to indirect causes (BMMS 2010). 14 percent of the deaths reported are due to injury and violence. The high incidence of injuries and violence as causes of maternal mortality indicate the need to address social issues to improve maternal health in Bangladesh[xi].

2.8 Proportion of births attended by skilled birth attendants

Despite improvements in Maternal Mortality Ratio, only 32 percent of births in 2011 were attended by a skilled birth attendant, namely a qualified doctor, nurse, midwife, Family Welfare Visitor (FWV), or Community Skilled Birth Attendant (CSBA). The assistance at birth is also determined by background characteristics: 54 percent of women in urban areas, 71 percent of women who have completed secondary or higher education, and 64 percent of women in the highest quintile are assisted by skilled birth attendants[xii].

A huge number of deliveries continue to be attended by traditional birth attendants without any formal training and are not connected to or supported by the health system, causing women to be deprived of the continuum of care to be provided by the public hospitals and public health facilities. Most of the UH & FWCs are not providing delivery services. Gonoshasthaya Kendra (GK) a

national non government organization reports a tremendously improved MMR in its working area covering 1 million people where TTBAs are supported by different levels of health personnel, thereby ensuring safe delivery. Although there is no specific data about PMR in our national level, on Gonoshasthaya Kendra reports from 2011 to 2015 show the present perinatal mortality rate to be 8.55 in their catchment area.

Bangladesh has made significant progress towards achieving the Millennium Development Goal 5 target of 75 percent reduction in the Maternal Mortality Ratio (MMR) with very low use of skilled birth attendants, a low caesarean-section rate and persistent regional variation in the use of maternal health care services. The southwest region (Khulna Division) performs relatively better while the north eastern Sylhet division lags behind with very low use of maternal health services.

This regional variation in the use of services exists within the broader context of a service programme directed and implemented centrally through the Department of Health and Directorate General of Family Planning of the Ministry of Health and Family Welfare (MOHFW). At the policy level, the strategic approach of the World Health Organisation (WHO) of skilled birth care with a back-up support from referral facilities is well accepted.

2.9 Availability of basic emergency obstetric care and comprehensive emergency obstetric care

The health, nutrition and population sector of Bangladesh has adopted a national strategy on maternal health, focusing on emergency obstetric care (EmOC). This strategy focuses on early detection, appropriate referral of complications, and improvements in quality of care[xiii]. Currently, 59 district hospitals and 70 out of 97 Maternal and Child Welfare Centres (MCWCs) provide comprehensive EmOC services at district level. At the tertiary level, 18 public medical college hospitals and 4 out of 25 specialised hospitals provide comprehensive EmOC services. Also, 133 of 427 UHCs have been upgraded to Comprehensive Emergency Obstetric Care (CEmOC) facilities. This establishment of EmOC facilities is in line with the WHO criteria; however performance data from the BDHS shows only 70-80 percent of upgraded UHCs function as comprehensive EmOC facilities[xiv]. Absence of trained medical personnel (trained obstetrician and anaesthetist), lack of commitment to serving rural areas and lack of trained anaesthetists are the major barriers to full coverage of of EmOC service provision[xv].

Case Study-1

Right to ANC at grass-roots level:

Naripokkho has taken various initiatives to increase awareness in and mobilize marginalized women to demand maternal health services from public health care institutions. Formation of women's groups within Women's Health and Rights Advocacy Partnership (WHRAP) project is one of those initiatives. Members of Women's Groups meet once a month. In the meetings, assigned staff of Community Based Organizations (CBO) discuss different issues such as available services at Union Health and Family Welfare Centres (UHFWC), women's health and reproductive rights, care and services during pregnancy period, eclampsia, family planning methods and their availability, neonatal and child health care and postnatal care of mothers and so on.

Duli Rani is a regular member of one of these groups in *Ailapatakata* Union, of Barguna district. Like other members, she learnt about her health rights through discussions while she was attending the meetings. She knows how many times a pregnant woman should go for antenatal check up, why and how it helps a pregnant woman. She also knows where the services are available. Shortly after joining the women's group, *Duli Rani* came to know that her daughter *Anjana* was pregnant. She brought her daughter to the Union Health and Family Welfare Centre (UH&FWC) for antenatal check up. A Family Welfare Visitor (FWV) demanded Tk. 100 to issue a registration card for service, which is supposed to be free of cost. She requested the FWV to provide the service for free, but in vain.

Duli Rani raised the issue in their Women's Group meeting where it was decided that four members of that group would go to the UH&FWC together and demand the registration card be issued free of cost. Initially the FWV refused. The group members told her that they knew all about the services and the costs, and if needed they would go to the higher authorities to demand their rights. The FWV realised that the women were aware about their rights and agreed to issue a registration card free of cost.

2.10 Antenatal Care (ANC)

Due to the availability of the service, Antenatal Care (ANC) seeking has increased steadily over time from 30 percent in the 1996-1997 BDHS survey to 55 percent of births in the 2010 BMMS survey, among those seeking at least one ANC from a medically trained person. The percentage of women who had no ANC at all has declined from 44 percent in 2004 to 21.4 percent in 2014[xvi]. PNC still remains an important issue because 2/3rd of maternal deaths occur after delivery.

2.11 Perinatal Mortality Rate (PMR)

Despite making huge efforts to improve Perinatal Mortality Rate (PMR) it is still high. Although the overall neonatal death rate is decreasing (from in 2007 to in 2011: (32) to (28) per thousand live births, BDHS 2014), neonatal death contributes to 60 percent of child mortality with most of the deaths occurring within the first 7 days. Data on still birth rate is not available in 2014. But previous data from 2011 BDHS, information on stillbirths is available for the five years preceding the survey. The perinatal mortality rate in Bangladesh is 50 deaths per 1,000 pregnancies, which is 9 percent lower than the level observed in the 2007 BDHS (55 deaths per 1,000 pregnancies). Perinatal mortality is high among teenage mothers, mothers aged 40-49 and highest among first pregnancies (71 deaths per 1,000 pregnancies). Perinatal deaths are composed of pregnancy losses occurring after seven completed months of gestation (stillbirths) and deaths within the first seven days of life (early neonatal deaths). The distinction between a stillbirth and an early neonatal death is a delicate one, often depending on the observed presence or absence of some signs of life after delivery. The causes of stillbirths and early neonatal deaths overlap, and examining just one or the other can understate the true level of mortality around delivery. For these reasons, it is suggested that both events be combined and examined together.

2.12 Infant Mortality Rate

The Infant Mortality Rate gives the number of deaths of infants under one year of age in a given year, per 1,000 live births in the same year; included is the total death rate, and deaths disaggregated by sex, *male* and *female*.[xviii] This rate is often used as an indicator of the level of health in a country.

The Infant Mortality Rate declined from 87 in 1993-94 to 43 in 2011.[xix] A higher level of education among mothers has a positive impact on child survival. The infant mortality is 40 percent lower for children whose mothers have a secondary level of education than those with no education.[xx] Short birth intervals are also associated with increased risk of death among infants and children under 5.[xxi]

Table 3 : Infant Mortality Rate Chart

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2014
Bangladesh (Per 1000 Births)	71.66	69.85	68.05	66.08	64.32	62.6	60.83	59.12	57.45	59.02	52.54	50.73	48.99	38.00

2.13 Child Mortality

Bangladesh has achieved success in terms of reducing under-5 child and infant mortality. The following table shows the significant reduction of value of parameters from 2007.

Table 4 : Progress in Reduction of Child Mortality

Period	Neo-natal Mortality	Post-natal Mortality	Infant Mortality	Child Mortality	Under-5 Mortality	Data Source
2007-2011	32	10	43	11	53	BDHS 2011
2010-2014	28	10	38	8	46	BDHS 2014

3. Adolescent and young people's sexual and reproductive health

The ICPD Programme of Action urged governments to address adolescent sexual and reproductive health issues as well as substantially reduce all adolescent pregnancies. In this section we look at key indicators such as the Adolescent Birth Rate (ABR), and the availability of the full range of adolescent sexual and reproductive health services, to assess access to health care for adolescents irrespective of marital status.

3.1 The Adolescent Birth Rate (ABR)

The age of the largest segment of the population of Bangladesh falls within the range of 15-25 years. BBS census data shows that, out of 132 million total population, nearly one-third is composed of adolescents and youth (age 10-24 years). Adolescent Birth Rate (ABR) per 1000 women has decreased significantly since 1990, from 179 to 157 in 1995 to 128[xxii] in 2009. We can clearly see the high rate prior to ICPD in 1994 in the following table.

Table 5 : Adolescent birth rate by year[XXIII]

Country	1990	1991	1994	1997	2000	2001	2003	2009	2014
Bangladesh	179.0	159.0	157.0	147.0	134.0	146.0	133.0	128.0	113.0

However, despite decline in the ABR, it is still too high. High adolescent fertility is one of the key SRH issues in Bangladesh. Data from the BDHS 2014 survey shows that 31 percent of adolescent girls aged 15-19 are already mothers with at least one child and 6 percent are currently pregnant. Early marriage and childbearing is more common in rural areas compared to urban areas.

Specific recommendation is to reduce ABR and improve access to adolescent friendly SRH services among adolescents irrespective of marital status.

3.2 Availability and range of sexual and reproductive health services for adolescent girls

The Government of Bangladesh has put into place the Bangladesh Adolescent Reproductive Health Strategy (2006). This strategy's action plan promotes major points of interest, such as delayed marriage, counselling and developing adolescents' awareness on personal hygiene practices.

Adolescents often lack the relevant reproductive health information and are thus unaware about their choices, about how to make responsible decisions, and how to negotiate sexual relationships. "Effective dissemination of adolescent reproductive health knowledge and information" through school curricula is identified as one of the strategies but has been left behind in implementation. Naripokkho's observations have shown that teachers remain unaware and unwilling to engage in any discussion with the students regarding these issues. They often skip the chapters, or ask students to read them at home. Moreover, information contained in the chapters do not cover all aspects of reproductive health, nor do they generate a complete understanding of the topic.

About 75 percent of rural girls in Bangladesh are married before reaching their sixteenth birthday and some even before they reach puberty. Conservative attitudes and traditions particularly in rural societies affect the health of rural adolescents, especially girls. They are pressurized into early marriage. Mothers in the 15-19 age group represent a share of 20 percent of total births. The mortality risks for children born to teenage mothers are substantially higher than those born to adult mothers. It has been shown in the health studies that an adolescent faces the highest health risks during pregnancy.

In Bangladesh, 20 percent of the births in adolescents are considered inappropriate and a considerable number of these pregnancies are unwanted. Unlike the growth rate, mortality rate for adolescent mothers is higher than the national average. Children born to young mothers are more likely to die early as both the mothers and their children are highly risk prone.

Research on the population sector of Bangladesh has revealed that about 19 percent of births from adolescent mothers are exposed to higher risk of death. Antenatal, neonatal and postnatal care for adolescent mothers is inadequate with very low usage. Adolescents have inadequate sex education. One study suggests that the vast majority of rural adolescents have never heard of Sexually Transmitted Diseases (STDs) and AIDS[xxiv].

As the adolescent reproductive health strategy is new, it remains to be seen how strong the government's commitment is to improving the universal access and rights of adolescents to SRH. However, there are some initiatives by INGOs and UN Agencies in making sexual and reproductive health services available to adolescents in the country.

'Bangladesh's national youth policy (2003) simply states "*A special initiative will be undertaken to give concrete ideas to adolescents and related people on adolescent reproductive health*". This statement does not specifically refer to education and no further guidance is given in the policy.[xxv] Some INGOs have counselling programmes for adolescent girls which are proving successful. These include lessons on developing skills to negotiate with their husbands/future husbands regarding when to have the first child and learning to be more in favour of delaying the first pregnancy.

4. HIV and AIDS

The ICPD Programme of Action called for the prevention and reduction of the spread of, and the minimisation of the impact of, HIV infections, and ensuring that HIV–infected individuals have adequate medical care and are not discriminated against.[xxvi] In this section, we look at key indicators that point to the status of sexual health of the people in the country, including the prevalence of HIV and AIDS among young people and persons at higher risk exposure as well as the availability of services for HIV and AIDS.

4.1 Prevalence and burden

Bangladesh is a low prevalence country in relation to HIV/ AIDS. The prevalence of HIV in Bangladesh is less than 0.1 percent in the general population and has remained less than 1 percent over the years, whether the total population is considered or when segregated for the most at risk and bridge populations (groups of men who are on the move and are likely to be clients of sex workers, such as truck drivers and rickshaw pullers). The percentage of young people between ages 15-24 living with HIV has also been less than 0.1 percent for both males and females.[xxvii]

According to the latest Serological Surveillance of Bangladesh (Round 9, 2011), the HIV prevalence among Persons Who Use Drugs PWUD, Female Sex Workers, Men who have Sex with Men (MSM) and Transgender groups (Hijras) was 0.7 percent.

The estimated number of people (all ages) living with HIV in 2012 remained at 8,000 (3,100-82,000), with estimated new infections at less than 1000 (500-19,000).[xxviii] However, there are indications of both the likelihood of incomplete reporting in terms of HIV prevalence and the potential for spread of the epidemic in Bangladesh (NASP, 2012).

Active syphilis rate among street-based sex workers significantly declined in three of the four sites sampled. Among hotel or residence based and casual sex workers no change was observed in syphilis rates except in hotels in Dhaka. 3 percent of young people of ages 15-24 living with HIV/ AIDs is <0.1(<0.1)-<.1). The number of infected female adults was <1000 (<100-1300) in 1994-96, and in 2012 it is 2700 (1000-2800).

There is a national HIV/AIDS committee in Bangladesh. Currently, under the 3rd National Strategic Plan (2011-2015), the following key objectives are being implemented:

A) Implement services to prevent new infections, and ensure universal access to treatment, care and support services for people infected and affected by HIV;

B) Strengthening multi-sectoral HIV/AIDS response, strategic information systems and research for evidence based response to HIV.

Currently most of the programmes in Bangladesh are focused on prevention of HIV among persons at higher risk of HIV exposure.[xxix]

Transgender people face social exclusion and discrimination. Often they are stigmatized and cannot avail proper education and jobs. So they are left with no other choice but to engage in the sex industry and thus are potentially at a higher risk of exposure to HIV, ranging from 8 percent to 68 percent. Yet they remain overlooked in the HIV and AIDS response worldwide.

In Bangladesh the transgender community are considered victims and vectors of HIV/AIDS and other sexually transmitted diseases, potentially passing the infection from one partner to another.

Social exclusion and stigma encourage discrimination with regards to their access to sexual health care services, since their gender identity is not officially accepted. The transgender community received official recognition as a third gender in Bangladesh in 2013 . In the given changed scenario, where people are now aware about their rights to health provisions, creating better access to health care services among transgender population should now become easier.

4.2 Availability of services

HASAB (HIV/AIDS and STD Alliance Bangladesh) is one of the national, leading Non Government Organizations (NGOs) in Bangladesh devoted to the field of HIV/AIDS/STI for the past twelve years. It emerged as a specialized agency with experience in grant management and capacity building (technical, managerial and administrative) for smaller NGOs, CBOs and Faith Based Organizations who are involved in prevention, control, care and support of HIV/AIDS infected group's.[xxx]

The provision of Antiretroviral Drugs (ARVs) are patchy and depend on the NGO's funding and support as there is still no national provision of ARVs. ARVs are manufactured by two companies in Bangladesh but they provide only limited first-line treatment, and no paediatric formulations are available. CD4 counts and more complicated diagnostic tests are available.

Through 146 drop-in centres in 44 districts, UNICEF has been supporting HIV/AIDS prevention activities among those most at risk of contracting the virus: injectable drug users, mobile populations, men who have sex with men, sex workers and their clients, and children forced into commercial sexual exploitation. The centres provide health care (including treatment for sexually-transmitted infections), crisis shelter, counselling, health education, rest and recreation facilities, as well as referral and outreach services. The centres have distributed over 6.6 million condoms, 2 million syringes and 1.3 million extra needles between January and September 2008. UNICEF will progressively withdraw from the drop-in centres as the Government of Bangladesh takes full responsibility for this project from 2009[xxxi].

4.3 Availability of sexual and reproductive health services at different levels of care

Bangladesh is often cited as one of the most successful examples in popularizing its family-planning programme. The Contraceptive Prevalence Rate (CPR) of 45 percent among the eligible couples in 1993-1994 is considered a commendable success despite the existing poor level of socioeconomic development in the country. The family-planning programme has been equipped with 35,000 service outlets, most of which are organized at the district level and below. The activities are most intense at the union level, with 3,000 Union Health and Family Welfare Centres (UHFWCs), 1,275 rural dispensaries, and 23 Mother and Child Welfare Centres (MCWCs). At the village level, basic maternal and child health and family planning (MCH-FP) services are provided, free of charge, by the staff of FWCs at the satellite clinics at the rate of 30,000 clinic-days per month. Besides, 23,500 Family Welfare Assistants (FWAs) provide additional free doorstep services (3). The methods of contraception include pill, IUD, condom, and sterilization. Although injectables are available to women on a limited scale for a decade, their use has soared since 1990 (2). Intrauterine Devices IUDs are inserted at the FWCs and satellite clinics, and sterilizations are performed at the Upazila Health Complexes (UHCs).[xxxii]

Recently, government has initiated a programme to insert IUDs during the post partum period or immediately after MR. Before that, couples/clients are consulted.

For ensuring the continuum of care—ANC, PNC, skill delivery—Bangladesh Government has an extensive network, from community clinics to specialized hospitals at central level. Identification of reproductive morbidity such as fistula, breast cancer, cervical cancer, uterine prolapse, or STDs, HIV/AIDS and their treatment is offered at different setups, in collaboration with national, international and UN agencies.

Table- 6 : Countrywide FP Service Outlets and Institutions[xxxiii]

1. National Level

- Azimpur Maternity and Child Health Training Centre
- Mohammadpur Fertility Service and Training Centre
- Two Model Clinics attached to two Medical College Hospitals
- Family Welfare Visitors Training Institute (FWVTI) – 12
- NGO Clinics -05
- Population, Health and Nutrition Cell - Bangladesh Betar
- Population Cell - Bangladesh Television

2. District Level

- Model Clinics attached to Medical College Hospitals – 06
- MCH-FP Clinics at District Hospitals – 64
- Mother and Child Welfare Centres (MCWC) - 62*
- Regional Training Centre (RTC) - 20

3. Upazila Level

- MCH-FP Units at Upazila Health Complex (UHC): - 407*
- Mother and Child Welfare Centers (MCWC) - 12*
- NGO Clinics - 68

4. Union Level

- Union Health and Family Welfare Centres (UH&FWC) – 3,500*
- Rural Dispensaries (RD) - 1,275
- Mother and Child Welfare Centres (MCWC) - 23*

5. Peripheral Level

- Satellite Clinic (Organized 30,000 per month);
- Domiciliary Services (CBD) 23,500 unit).
- Mother and Child Welfare Centres (MCWC) - 23*

5. Recommendations

5.1 Weak Implementation of SRH Policies and Programmes

Weak implementation and absence of necessary institutional arrangements are the main impediments to achieving the goals set in the different SRH related policies mentioned above. Stronger and effective coordination within the public sector and between the public and private sectors is required. Past achievements in Bangladesh have been obtained through major advances inter alia in female education, poverty alleviation, and job creation. Therefore these broader socio-economic policies and programmes should be pursued along with SRH policies and programmes in order to accelerate gains through a multi-sectoral thrust. The government should also strengthen its capacity to harmonize various policies and programs with specific SRH indicators. It should also ensure that the burden of contraception does not fall disproportionately on women as it does at present.

Obtaining sex-disaggregated data is a necessary step to understand gender-specific health trends and thereby make appropriate responses to improve women's health. Similarly, effective performance monitoring and programme evaluation efforts capture the distinct impact of programmes on girls, boys, women and men of all ages. All these can help provide actors with critical information in addressing barriers to access, inequalities or gaps, and to ensure that all population groups benefit from the interventions, including the most vulnerable. Many challenges remain in Bangladesh with regard to generating comprehensive data, analyzing such data within a gender-based framework, and disseminating and using it in a way that influences policy development and change.

Most people, both men and women, are not informed of Government policies. This lack of information is also present in implementing agencies. There is a lack of transparency about the implementation of programmes, initiatives and policies. There is a lack of unified data on implementation and a lack of gender analysis of the available information.

At field level, the monitoring of health workers and professionals is weak and there are gaps in their execution of their responsibilities. Doctors' presence at field level is not ensured. There is a general lack of accountability of health professionals to the population.

There is a lack of effective policies and measures to address the effects of climate change on women's health. The Government should take measures to address this.

We strongly urge the Government and all health providers, both Government and private, to increase the awareness of the provisions of various policies and of the contents of the programmes, both among the health service providers and among the general public. This would include creating awareness of the need for transparency and accountability of the health providers to the public, both women and men.

We also strongly urge the Government and all health providers, both public and private, to increase the awareness of the need for better and more accurate record keeping which will also contribute to greater accountability of the health service providers. Records and data of private and public sectors need to be brought together in a uniform manner, compiled and updated regularly though MIS (Management Information Systems) and shared in an open and transparent manner.

5.2 Adolescent sexuality, reproductive health education and early marriage

Specific SRH services, education, and other social programmes are needed to support adolescents and get them a healthy start. The SRH programmes and services that have skilled health providers, in combination with other social services including comprehensive sexuality education, can help prevent unwanted pregnancies, maternal mortality and morbidity, as well as sexually transmitted infections. The programmes and services should include counselling to prevent sexual violence and abuse and deal with its consequences. Vulnerable adolescents should be targeted as priority recipients of adolescent-friendly SRH services with quality, easy choice and accessibility. Therefore we demand that the provisions regarding adolescent reproductive health education be implemented fully and successful approaches to providing such education be scaled up and adopted by the Government.

Adolescents need to make informed choices and have access to quality health care including reproductive health care.

There is now discussion in government circles on the lowering of the marriage registration age for girls. We fear this will undermine the many gains

Bangladesh has made to date and put at risk the lives of young girls. Allowing children aged sixteen to be married contravenes various international conventions that Bangladesh is a signatory to and violates the rights of children to development and also to choice of when to marry and who to marry.

A unified database for birth registration and marriage registration should be set up to prevent child marriage by showing the true age of young women and men. Affidavits for the purposes of certifying age will not be acceptable. Various measures to prevent early marriage such as education stipends, media campaigns, awareness raising programmes, possibilities of formal employment and implementation of laws should be continued and strengthened to prevent early marriage.

5.3 Violence and abuse against women and girls

There is a plethora of laws and policy statements that condemn and specify actions against violence against women and girls. For example the National Children's Policy states that "Necessary arrangements shall be ensured so that the female children do not become victims of any sexual harassment, pornography and physical and mental abuses in various situations such as in the streets, including inside educational institutions" (Section 8.4).

We strongly urge the Government to ensure stricter enforcement of laws and effective implementation of policies on violence against women. Mass education campaigns to challenge and change norms that condone violent behaviour towards other human beings, be they children, women or other adult men, are a necessary component. Finally, women have to be supported through various programmatic and legal interventions to gain strength to protest against violence and to defend their bodily integrity.

5.4 Difficulties in Access and Inadequacies in health services

We strongly urge the Government to address regional, age and social differences in access to services and contraception and to take measures to ensure that infrastructure, supplies, skilled and adequate human resources, effective referrals, regular monitoring, ensuring accountability of service providers and allocation of enough financial resources is ensured.

In addition to these, the following recommendations should be addressed:

- Improve skilled birth attendance during delivery
- Strengthen 24/7 safe delivery & essential newborn care services by SBA, properly linked with TBAs
- Improve ANC as well as quality of antenatal care especially among rural women.
- Improve PNC in & outside of health centres
- Ensure Government's contribution to increasing expenditure on sexual and reproductive health care services
- Establish strong referral system to ensure emergency obstetric care and essential newborn care services
- Validate the recording process for accurate maternal death audi
- Ensure sexual and reproductive health services for marginalised (e.g., poor women) and excluded groups (e.g., sex workers, LGBTIQ groups and women with disabilities)

Footnote

[1] State Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake: To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle; To adopt progressive legislative and other measures, including sanctions where appropriate, prohibiting discrimination against women; To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination; To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation; To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise; To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; To repeal all national penal provisions which constitute discrimination against women.

[2] State Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: c)The same rights and responsibilities during marriage and at its dissolution;

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About Naripokkho

Naripokkho is a membership-based, women's activist organisation working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice. Since its founding in 1983, Naripokkho has met every Tuesday to discuss problems, issues and strategies related to these concerns. These discussions form the basis for Naripokkho's programmes and activities, which include campaigns, cultural events, training, research, lobbying and advocacy, and the maintenance of a regular participatory discussion forum. Occasionally this leads to a specific project, which is carried out with grant funding. However, most of Naripokkho's activities are voluntary and financed through resources that are earned by the membership. Naripokkho's work is focused on the following six inter-related thematic areas:

- Equality and the Political Empowerment of Women
- Violence Against Women (VAW) and Women's Human Rights
- Women's Health and Reproductive Rights
- Communal Harmony
- Women's Economic Rights

Naripokkho has extensive experience in developing sustainable networks and alliances as well as in conducting research, workshops, seminars, training and national level conferences.

Naripokkhos campaigns, projects and advocacy interventions are conducted by members with the support of paid staff. Naripokkho has through the collective knowledge and experience of its membership and the engagement of individual members in various movement-based and advocacy roles, has established a strong reputation of expertise in gender and rights issues.

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