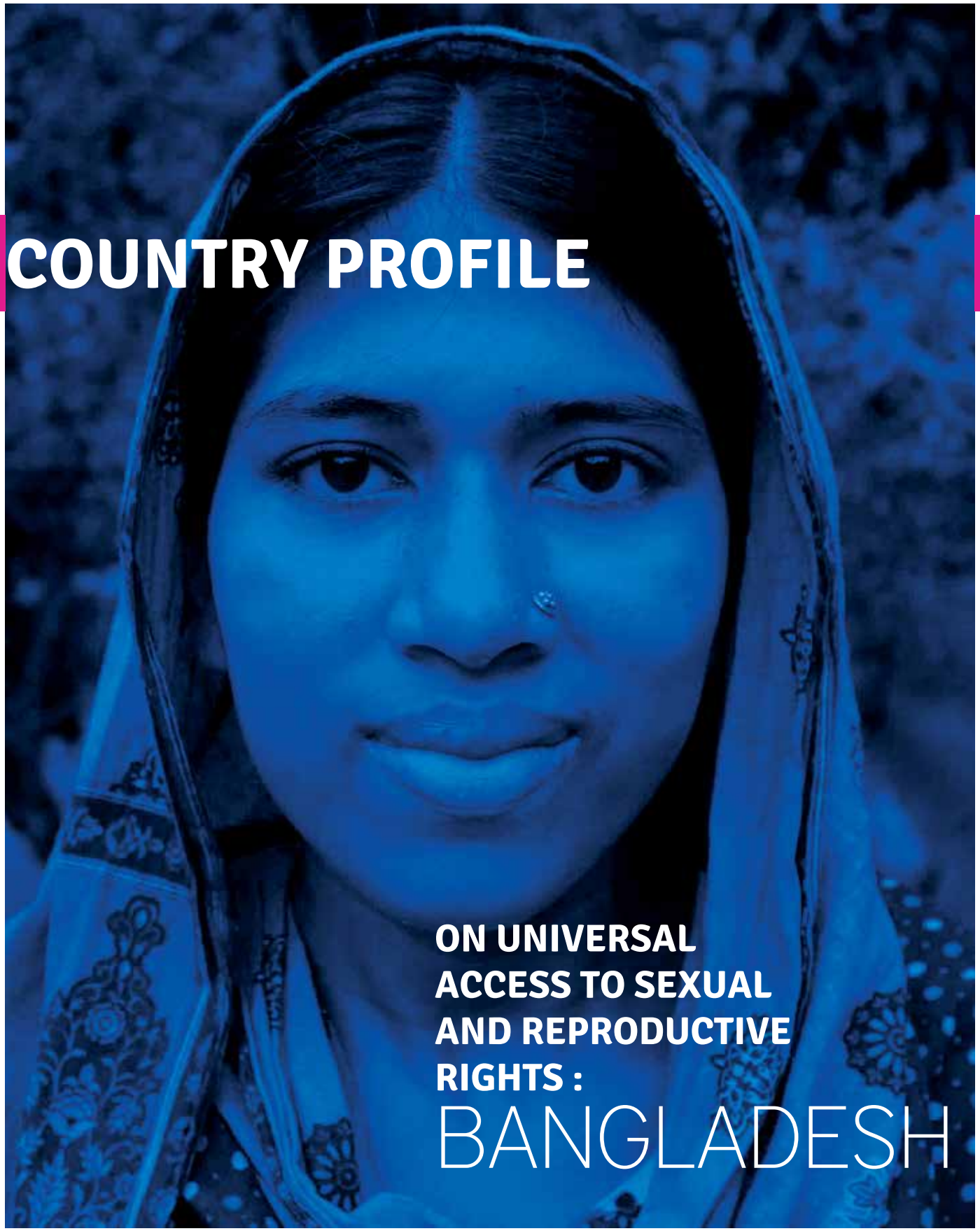

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS : BANGLADESH

নারীপক্ষ Sida arrow asian-pacific resource & research centre for women

Contents

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
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
KP	Key Population
MDG	Millennium Development Goal
MIS	Management Information System
MCWCs	Mother and Child Welfare Centres
MMR	Maternal Mortality Rate
NGOs	Non Government Organizations
NWDP	National Women Development Policy
PMR	Perinatal Mortality Rate
PHC	Primary Health Care
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 Counseling and Testing
WHO	World Health Organization
WHRAP	Women's Health and Rights Advocacy Partnership

1. Introduction

Having the right to a safe, enjoyable sex life, being able to decide for oneself if and when to have children, having access to non-judgmental services, not being subject to gender based violence are all issues that encompass sexual and reproductive health rights. Such a human rights-based approach to sexual and reproductive health was promoted at the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women in Beijing. The ICPD Programme of Action (PoA) commits governments to ensuring the realization of reproductive rights for all, including women and adolescents, and to providing a comprehensive range of sexual and reproductive health information and services. The Beijing Platform for Action recognizes that women's human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

Women and girls in Bangladesh face various barriers and impediments that make it difficult if not impossible for sexual and reproductive health rights to be realized. The basic issue of awareness regarding sexuality and reproductive health is considered a taboo subject for young girls and adolescents. One-third of the population in Bangladesh consists of adolescents between 10-19 years of age (BBS, 2011)[1] who have limited knowledge of SRH issues including contraception, sexuality, family planning and sexually transmitted diseases. Inclusion of curricula on sexuality and reproductive health in formal and non-formal educational sectors is mandated but weakly addressed which is a missed opportunity as the enrollment rate at school for girls is 94% for the age 6-10 years although this drops to 35% when they reach 16 years of age (BDHS 2014). Therefore if and what they know is often incorrect and is garnered from their friends or other social contacts, who also have limited knowledge on these issues. Coupled to this unawareness is early marriage; according to a World Bank report as well as the UNICEF state of the World's Children report 2013, more than 66% girls in Bangladesh are married off before their 18th birthday. Globally, Bangladesh has the highest proportion of girls married under 15 (UNICEF 2014)[2]. According to a CEDAW summary report 2004, the actual age of marriage is much younger although the marriage registration age is 18 years for women and 21 for men[3]. The median age at marriage for women is still two to three years below the legal minimum age, indicating that laws or policies alone do not guarantee social change. Violence against women (VAW) is another major concern and a key determinant of the status of women. The results of VAW Survey 2015 identified that as many as 72.6% of ever married women have experienced one or more forms of violence by their husband at least once in their lifetime. while 54.7% experienced violence during last 12 months. 27.3% women faced sexual violence by their partners (VAW Survey, BBS 2015)[4].

There is no single policy or strategy document issued by the government on Sexual and Reproductive Health Rights (SRHR). Instead, elements of SRHR such as- maternal health, family planning, maternal mortality, adolescent reproductive health, menstrual hygiene management etc. are included in various other policies, like the 7th Five Year Plan, the National Population Policy (2012), Health Policy (2011), Maternal Health Strategy 2011-2016, Integrated National Policy on HIV/AIDs and STI-related Issues and Adolescents Reproductive Health Policy 2003. The main aim of the National Population Policy 2012 (see Box no. 1) is population control, with the objective of empowering women and eliminating gender discrimination and removing barriers to family planning and maternal and child health care. However, most of the family planning methods are for and use by women only. Thus the onus of contraception falls on women, and usually without access to choice of contraceptive method.

Similarly, the Health Policy which despite being quite comprehensive does not address the issue of sexuality as a whole.

Naripokkho's experience of work on women's reproductive health and rights has shown that many factors (cultural gender norms, traditional values and practices, poverty and lack of knowledge about available services) prevent women from exercising their rights to access sexual and reproductive health services. The Beijing Platform of Action stressed that references to culture, tradition and religion must never be used to disregard the rights of women. However, the realty in Bangladesh is culture and tradition along with religion play a very big role in

Box No. 1

Objectives of National Population Policy 2012:

4.1 **Lower the Total Fertility Rate (TFR) to 2.1 by increasing the rate of prevalence of contraceptive users to 72%, and achieve NRR = 1 by the year 2015**

4.2 **Ensure the availability of family planning methods to eligible couples by providing easy access to reproductive health services including family planning methods; build awareness among the poor and the adolescents of family planning, reproductive health, reproductive tract infections and HIV/AIDS; and prioritize counseling services**

4.3 **Reduce maternal and infant mortality, and take steps to improve health care for mothers and children by ensuring safe motherhood**

4.4 **Ensure gender equity and women's empowerment, and strengthen activities to eliminate gender discrimination in family planning and maternal and child health care programs**

4.5 **Undertake short-, medium- and long-term plans for developing the population into human resources with the participation of the concerned Ministries**

4.6 **Ensure easy access to information on reproductive health including family planning at all levels**

Source: National Population Policy 2012, http://ageingasia.org/wp-content/uploads/2015/07/Bangladesh-Population-Policy-2012.pdf

determining what information is available on SRHR and on women and girl's access to services. Furthermore, lack of skilled, motivated, gender sensitive health care providers, weak referral links and travel arrangement from home to facilities, inadequate and restricted EmOC provided by health facilities, all result in poor quality of services and precludes their optimal utilization.

2. Sexual and Reproductive Rights in Bangladesh

2.1 Population and Health Policies and Strategies

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. Bangladesh has signed off on many international treaties and covenants related to SRHR. Bangladesh adopted the ICPD Program of Action (PoA) and Principle 8 of which says[5], "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health". Moreover, Bangladesh is also committed to implement other international treaties such as- CEDAW, ICCPR, ICESCR, CRC and Beijing PFA as a signatory. However, the commitments are poorly implemented and sexual and reproductive health and rights is not well integrated in policies of Bangladesh. In the Article 15 (a) of the Constitution of Bangladesh[6] medical care is stated as a basic necessity of life since it says "It shall be a fundamental responsibility of the State....(a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care". Moreover, article 18(1) of the constitution states that improve public health and nutrition is a primary duty of the State. The article says[7], "The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of .drugs which are injurious to health". Therefore, health is recognized only as fundamental responsibilities and primary duties of the State rather than fundamental rights of the citizen.

Bangladesh adopted the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) where in the Article 12 (1)[8] it

says “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”. According to the BDHS 2014 report, contraceptive prevalence rate is 62% with 27% of women are using any modern method. Only 6% of men use condom as a family planning method and female condoms are not available. According to the article 12 (2) of CEDAW, “Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”. Bangladesh government has started a Maternal Health Voucher Scheme from 2008 that gives an allowance of 500Taka per month to poor pregnant women at upazila level for their health care. However, the money is distributed every 6 months instead of every month.

Bangladesh has several policies such as the National Population Policy (2012), National Health Policy (2011), National Nutritional Policy 2014 and National Policy for Women’s Advancement 2011 (see Box no. 2) that refers to women’s access to reproductive health services and maternal and new born services. The specific objective 1 of National Health Policy 2011[9] ensures primary and emergency health care services for all and specific objective 3 talks about encouraging people to take health care service on the basis of rights and dignity. Government has set up one community clinic per 6000 people (13136 in total)[10] at union level to provide primary health care for rural people. Moreover, government has launched Comprehensive EmOC (CEmOC) in 59 district hospitals and in 132 Upazila Health Complex along with EmOC services at all upazila level hospitals[11]. However, this service is poorly functional due to lack of adequate staff specifically of the “pair group” (1 gynecologist and 1 anesthetist).

In addition to these policies in Bangladesh, several strategies and guidelines also exist. The National Neonatal Health Strategy and Guidelines for Bangladesh 2009[12] addresses the health service needs of mothers and new born babies i.e. giving attention, taking care and nursing for the most vulnerable. This guideline focuses on postnatal care in health facilities to be implemented in a structured way. The National Neonatal Health Strategy and Guidelines 2009 incorporate many maternal health interventions and indicators and recognize the need to train health workers in both maternal and neonatal health.

Adolescent Reproductive Health Strategy[13] facilitates women and adolescents with decision making capacity, negotiation skill, and sexuality education in the school curriculum. The strategy also recognizes the need to reach adolescents who are out of school, engaged in various kinds of employment, street children and disabled children.

Bangladesh adopted National Policy on HIV/AIDS and STDs in 1996 which emphasizes four cross-cutting priority issues: human rights; gender; behavior and information; and edu¬cation and communication[14]. The 3rd National Strategic Plan for the HIV and AIDS Response 2011-2015 of the Government of Bangladesh has as its first objective the implementation of services to prevent new HIV infections and ensuring universal access. The strategies under this objective include minimizing transmission of HIV and other sexually transmitted infections among sex workers, males having sex with males, hijra, people who inject drugs as well as young people. Supportive activities for achieving this objective have also been delineated in the strategy document and include reducing stigma and discrimination, violence and exploitation and addressing legal/policy obstacles to service provision. The prevalence of HIV is low in Bangladesh but nonetheless prevention efforts aimed at those most at risk and who are marginalized have been expanded to different parts of the country but efforts to decriminalize some of these behaviors has not materialized into legal changes. In 2006 Bangladesh developed its first Antiretroviral Therapy (ART) treatment guidelines that enable people living with HIV to buy subsidized antiretroviral drugs from specified pharmacies. Moreover, the second objective of the 3rd National Strategic Plan is to provide treatment, care and support to people infected with and affected by HIV and AIDS. However, less than 20% of the approximately 10,000 people estimated to be living with HIV have been treated with ARVs.

It is to be noted that, at the level of implementation, there are various players including national and international NGOs, UN agencies, private clinics and research institutions along with the government. They have programs and projects targeting special groups for the promotions of sexual and reproductive health rights. The government has promotional programs

on safe motherhood, menstrual regulation training and it is widely practiced. The government is initiating public and private partnership that has had wide impact.

Maternal health services are addressed in the 'Bangladesh National Strategy for Maternal Health 2010[15]. There is no Sexuality Education policy but there is 'Bangladesh Adolescent Reproductive Health Strategy 2006'. The National Women Development Policy (NWDP) of 2011 deals with a wide range of issues that are directly or indirectly linked with women and their development. Health and nutrition is one of those important issues that the NWDP attempts to address[16]. Quite contrary to the Medical Negligence and Fraudulent Practice in Private Clinics where a culture of denial exists, the Health Policy at least admits that due to a shortage of human resources, funding and legal aid the regulatory bodies in the medical sector are not effective enough. It also proposed the review and modification of existing policies in this regard (NHP, 2011:12).

Bangladesh does not have specific laws or policies regarding grievance redress mechanisms for sexual and reproductive health services. Any violation or negligence in services is addressed by General Medical Negligence Act. ('The Consumer Rights Protection Ordinance, 2008','The Bangladesh Medical and Dental Council Act, 2010'). In addition to these laws, 'the Penal Code, 1860' could be taken into consideration, especially when medical negligence or fraudulent medical practices give rise to criminal liability. Apart from the laws, the code of medical ethics adopted by Bangladesh Medical and Dental Council, the regulatory body of medical and dental profession in Bangladesh, is of great importance. Medical negligence and proper management and monitoring of public and private health care services are matters of serious concern.

Box No. 2

Bangladesh Government's Policies and Strategies Regarding Health

1. **National Health Policy 2011**
2. **National Population Policy 2012**
3. **National Nutritional Policy 2014**
4. **National Policy for Women's Advancement 2011**
5. **Menstrual Regulation Policy 1979**
6. **Maternal Health Strategy 2001**
7. **Neonatal Health Strategy 2009**
8. **Adolescent Reproductive Health Strategy 2006**

2.2 Child, Adolescent, Youth Health and Child Marriage:

2.2.1 Policies and Strategies relating to Child, Adolescent, Youth health

The Adolescent Reproductive Health Strategy (2006)[17] recommends the inclusion of comprehensive sexuality education in school curriculum, with special services for out-of-school and married adolescent girls. The strategy also recognizes the necessity to reach adolescents who are out of school, engaged in various kinds of employment, street children and the disabled. Peer-based approaches to training (especially life skills training and vocational training) are promoted. The Strategy identifies the following priority activities to make the curricula more effective: "a) review and revise existing curricula based on needs assessment; b) training of teachers on the revised curricula; c) implementing monitoring systems to ensure classroom teaching of the curricula." It recognises that "special efforts will have to be made to reach adolescents who are out of school, married adolescent girls, those in various kinds of employment, street children and disabled young people..." and that peer-based

approaches and training (especially life skills training and vocational training) are promoted to address these groups.

Bangladesh's National Youth Policy (2003)[18] 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.

There is a plethora of policy statements that condemn and specify actions against violence against women and girls. For example, the National Children Policy 2011 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 on the streets or inside educational institutions (Section 8.4)[19].

2.2.2Adolescent Reproductive Health and Early Marriage:

According to the The Child Marriage Restraint Act (1984 Amendment Ordinance), the minimum age of marriage is 18 for women and 21 for men. According to the Child Marriage Restraint Act 1929, amended in 1984: "The law states that whoever performs, conducts or directs any child marriage shall be punishable with simple imprisonment which may extend to one month, or with fine which may extend to one thousand Taka, or with both, unless he proves that he had reason to believe that the marriage was not a child marriage." This is so far not implemented. On the contrary current government has proposed a reduction in the legal age of marriage registration from 18 to 16. However, under the protest from women rights organizations the Ministry of Women and Child Affairs declared that they drafted a law to keep the legal age of marriage for girls at 18 years but it can be lowered at 16 under 'special circumstances'. This special circumstance includes cases when a girl elopes with a man and refuses to return or becomes pregnant before marriage.[20]

The median age at first marriage among women is 15.5 years compared with 24.2 for men the same (25-49) age. In Bangladesh, 2 percent of women are married before the age of 11. The prevalence of child marriage is still high in Bangladesh, 64 percent of all women aged 20–24 were married before the age of 18 and 86 percent married by age 20 (BDHS 2011)[21]. In Bangladesh, the actual age of the marrying individuals is concealed when an early marriage takes place. The marriage registrars usually confirm the age by looking at the birth certificate. But in reality, in most of the cases the girl's age is raised and a false birth certificate is prepared and affidavits for the purposes of certifying age are common. Hence, under-aged marriages remain undetected (National survey on early marriage 2013)[22].

Although progress has been slow, various measures have contributed to the gradual increase of girls' age at marriage, even though the interventions to increase the age at marriage may not be the same in different parts of the country. School stipends have encouraged girls to continue in schools. Families and the girls themselves are aware of the need for increased education and skills (through various government and NGO media campaigns and messages). An increasing number of NGOs are working to prevent payment of dowry and early marriages but this needs greater effort from all concerned. In many countries the choice of young women entering into formal sector employment is associated with marriage at a later age, delayed and reduced childbearing. However, only one in six teenage girls in Bangladesh is employed.

A unified database for birth registration and marriage registration showing the actual ages of young women and men is yet to be set up to prevent child marriages. National Population Policy 2012 of Bangladesh states that integrated initiatives efforts must be made through government and non-government organizations, and religious and social institutions in order to change the practice of child marriage. It aims to do so by educating adolescents in health issues and life skills and by organizing dissemination workshops, essay writing and debating competition etc. in schools and colleges regarding maternal and child health, reproductive health and family planning issues.

Recently, the Ministry of Health and Family Welfare, through the Directorate of Family Planning as well as financial and technical support of UNFPA has developed a National Plan of Action on Adolescent Reproductive Health. It is expected that this comprehensive document will address the "Demographic Dividend" issues mentioned earlier and will contribute to a greater extent towards a comprehensive and concerted effort on behalf of stakeholders of all levels, to meet unmet reproductive health need of adolescents in Bangladesh.

2.3 Gender-based violence

2.3.1 Legislation related to gender-based violence

In Bangladesh there are various laws for certain acts of violence against women. These include 'Prevention of Women and Child Repression Act 2000, Amendment 2003' addresses rape. In this Act, rape is defined as vaginal penetration only by the penis, where the burden of proof lies on the complainant. There are also laws against sexual abuse and harassment. The other laws to prohibit violence against women are 'The Dowry Prohibition Act 1980[23], 'Bangladesh Acid Crime Prevention Act 2002[24], 'Acid Control Act 2002[25, 26], and 'Domestic Violence (Prevention and Protection) Act 2010'. Some of these laws call for harsh punishments. For example, the Prevention of Women and Child Repression Act 2000 (Amendment 2003)[27] provides for a sentence of death or life imprisonment and financial penalty to a husband or any of his relatives who cause or attempt to cause death or grievous injury to a wife on account of dowry transaction. In 2011, the High Court ordered to use the term 'sexual harassment' instead of 'eve teasing' (see Box no. 3).

Box No. 3

A High Court decision declared on 26 January 2011 that the sexual harassment of girls and women is illegal, and it directed the government to consider the offence as sexual harassment instead of the term "Eve teasing". It also states that harassment through text messaging, multimedia messaging, email and phone will be considered as sexual harassment.

Source: The Daily Star, 27 January 2011,Stalking now sexual offence, Retrieved from: http://www.thedailystar.net/news-detail-171721

In Bangladesh, new laws are being legislated to protect and prevent violence against women but implementation of existing laws is ineffective because of many barriers that women face

Box No. 4

High Court Issues Rule on the Prohibition of "Two Finger" Test on Women and Girl Survivors of Rape

On July 2014, the High Court directed the Secretary, Ministry of Health and Family Welfare, Secretary, Ministry of Home Affairs, Director General, Directorate of Health Services, and the Inspector General of Police to show cause in four weeks as to why the so called 'two-finger test' undertaken upon women and girl rape complainants should not be declared to be without lawful authority and of no legal effect.

The Court asked the respondents to explain why their failure to prohibit the "two-finger test", resulting in discriminatory and arbitrary treatment against women and girls, should not be declared to be a breach of their constitutional duties and a violation of fundamental rights as guaranteed by Articles 27, 28, 31 32 and 35(5) of the Constitution. The Honorable Court also issued an interim direction upon the Secretary, Ministry of Health and Family Welfare to set up a committee with experts on criminal justice, forensic science, public health and women's rights, to develop a comprehensive guideline for police, physicians and judges of the Nari o Shishu Nirjaton Domon Tribunals, regarding examination and treatment of women and girls subjected to rape and sexual violence, and to report to the Honorable Court on this within a period of three months.

Source: Press Release on July, 2014, High Court Issues Rule on the Prohibition of "Two Finger" Test on Women and Girl Survivors of Rape, retrieved from http://plan-international.org/where-we-work/asia/bangladesh/about/publications/national-survey-on-child-marriage-by-plan-bangladesh-and-icddr-b/

including lack of knowledge so that women do not know where to get help and seek justice, difficulties are faced in lodging complaints and taking complaints further. For example, The Domestic Violence (Protection and Prevention) Act of 2010[28] and the Rules to the Act enacted on 2013 enables any victim to lodge a complaint with a judicial or metropolitan magistrate seeking protection from such violence. However, in reality, this is hampered by inadequate number of appointed enforcement officers at every sub-district level, police station, district and metropolitan area, additionally, delays in court proceedings, the influence of the accused, and corruption in the law enforcement agencies are impediments to receiving justice. The 'two finger test' is used on women used to testify the accusation of rape. However, this test is degrading to women and arbitrary treatment against women and girls. In 2014, the High Court issued rule on the prohibition of this test on women and girl survivors of rape (see Box no. 4). Laws regarding gender based violence are given in the Box no. 5.

2.3.2 Extent of gender-based violence

In Bangladesh, one in every five girls aged between 15 and 19 is sexually abused by her husband or partner (UNICEF 2014)[29]. The percentage of adolescent girls who ever experienced physical and/or sexual violence is 47. The proportion of women aged 20 to 49 years who ever experienced such violence is even higher in the country, close to 50 percent, with more than four in ten girls convinced that wife-beating is sometimes justifiable.

The recent survey on the prevalence of Violence against Women (VAW) carried out by the Bangladesh Bureau of Statics (BBS) in 2015 shows the highest rates of violence found so far. As many as 54.7 percent of currently married women reported having experienced some type of violence in the last 12 months. Among the different types of violence reported, psychological violence was the most common, followed by physical violence. Regarding violence against women by partners, the percentage of physical violence is 20.8 percent and sexual violence 13.3 percent but the incidence of emotional violence is 24.2 percent and economic violence is 6.7 percent[30].

Gender-based violence issues are now increasingly being reported compared to previous years. From the statistics of Bangladesh Police Headquarters, the number of incidents of women oppression, including those of rape, killing, abduction and sexual harassment, reached 2,08,597 in 2014[31]. Among these 46,060 were rape cases, 386 women were killed after being raped, 1,857 were victims of acid attacks, 64,540 were victims of violence in relation to dowry transactions and abduction cases totaled 38,429.

Higher reporting of incidents is a reflection of the awareness of the issue, demonstrating a conducive environment for enabling active accountability towards NGOs, organizations and pressure groups. It must be mentioned that various local and international organizations have also developed their own gender policies. Women activists and legal aid organizations are working as pressure groups, and recently the Domestic Violence (Prevention & Protection) Act 2010 was passed, enabling a woman to file a case against her own husband from her own home.

Regardless of the actual progress made to prevent or reduce the incidents of violence, Violence against Women and Girls (VAWG) in Bangladesh remains an issue, a fact which has emerged in serious public and professional discourse. Marital rape is not recognized by the law. There are no indications from published works that there has been progress in relation to this issue. In clarifying and addressing VAW, WHO defines Intimate Partner Violence (IPV) as "one of the most common forms of violence against women and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner."

Box No. 5

Laws related to gender-based violence in Bangladesh

1. Laws on Rape

Substantive Laws

- Penal Code, 1860 Section 375, Section 376
- Nari O Shishu Nirjatan Daman Ain, 2000 [Suppression of Violence against Women and Children Act, 2000], as amended 2003, Section 9

Procedural Laws

- Code of Criminal Procedure, 1898
- Evidence Act, 1872
- Nari O Shishu Nirjatan Daman Ain, 2000 [Suppression of Violence against Women and Children Act, 2000], as amended 2003, Sections 16, Sections 18 - 34 which provides for a sentence of death or life imprisonment and financial penalty to a husband or any of his relatives who cause or attempt to cause death or grievous injury to a wife on account of dowry; this act also penalizes other forms of gender based violence including – rape, acid violence.

2. Laws Against Domestic Violence

- Paribarik Shohings hota (Protirodh O Shurokha) Ain, 2010 [Domestic Violence (Prevention and Protection) Act, 2010] which enables any victim to lodge complaint with a judicial or metropolitan magistrate seeking protection from such violence;
- Paribarik Shohingshota (Protirodh O Shurokha) Bidhimala, 2013 [Domestic Violence (Prevention and Protection) Rules, 2013]
- Dowry Prohibition Act, 1980 made the taking and giving of dowry an offence punishable by fine and imprisonment
- Penal Code, 1860 (Sections 312–314) permits abortions only for saving the life of expectant mothers.
- Nari O Shishu Nirjaton Domon Ain (NSNDA), 2000 [Suppression of Violence against Women and Children Act, 2000], as amended in 2003.

3. Laws Against Acid Violence

- Acid Niyontron Ain, 2002 [Acid Control Act (ACA), 2002]
- Acid Oporadh Niyontron Ain 2002 [Acid Crime Suppression Act, 2002]
- Nari O Shishu Nirjaton Domon Ain (NSNDA), 2000 [Suppression of Violence against Women and Children Act, 2000], as amended in 2003.

4. Laws Against Human Trafficking

- Penal Code, 1860
- Children Act, 1974
- Manob Pachar (Protirodh O Daman) Ain 2012 [Human Trafficking Prevention and Suppression Act, 2012]

5. Others

- Speedy Trial Tribunal Act, 2002 Bangladesh 2004
- The Child Marriage Restraint Act (1984 Amendment Ordinance) raised the age of marriage from 16 to 18 for women and from 18 to 21 for men.
- The Muslim Family Law Ordinance, 1961 (Amended in 1985) regulates certain aspects of registration, divorce, polygamy, and inheritance.
- The Penal Code (Second Amendment Ordinance) provides capital punishment for causing grievous injuries, rape, dowry, deaths or acid throwing.
- The Family Court Ordinance, 1985 deals with causes of marriage, divorce, and the maintenance, guardianship, and custody of children.
- The Correctional Home for Juvenile Offenders (Ordinance 1974) provides rehabilitation programs for adolescent offenders under the supervision of magistrate.
- The Anti-terrorism Ordinance of 1992 provides punishment for all types of terrorism including teasing through making mockery of women or abducting children and women.

2.4 Abortion and its Legal Status

Although abortion is illegal in Bangladesh, the Director General of Family Planning (DGFP) of the Bangladesh Government issued a circular on February 03, 2015 based on the decision of 61st meeting of National Technical Committee where menstrual regulation (MR) is allowed within 10 weeks of pregnancy when conducted by paramedics and 12 weeks of pregnancy by medical doctors (MCH-Services Unit, DGFP 2015)[32]. 'Menstrual Regulation (MR) has long been included in the official policy and that the necessary support for MR services and training is to be provided by the DGFP.' Another government memorandum (1980) permits MR to be performed by a trained registered medical practitioner, and by any family health visitor (FWV), who has specific training in MR. It also specifies that the FWVs are allowed to perform MR from 10 weeks of LMP and doctors trained in MR are allowed to perform up to 12 weeks of LMP.

In Bangladesh, seven in ten ever-married women know about MR. Among those who have heard of MR, 9 percent of previously-married and currently married women have used it (BDHS 2011). In 2010, an estimated 653,000 women obtained MR. NGOs and private sector provides only 28 and 9 percent of MR respectively.

2.5 Legislation and Policies on Sexual Orientation and Gender Identity

In Bangladesh, same-sex sexual activity, whether in public or private, is illegal and punishable. According to the Penal Code, 1860 Section 377 "Unnatural Offences,": "Whoever voluntarily has carnal intercourse against the order of nature with man, woman, or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine. Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section." A report "Mapping exercise on HIV/AIDS law, ethics and human rights" published by the Bangladesh Ministry of Law, Justice and Parliamentary Affairs in 2002 states that Section 377 "violates [the] constitutionally protected right to privacy under the expanded definition of right to life and personal liberty."(Human Rights Watch 2003)[33] Thus section 377 is in conflict with the anti-discrimination clause and the right to equality before the law guaranteed by the Constitution of Bangladesh.

To change the present situation, the UN has taken initiatives under the United Nations Human Rights

Council (UNHRC), where in 2009, based on reports prepared by local rights groups of Chile and the Czech Republic, it made three recommendations to the Government of Bangladesh which, if implemented, would improve the legal status of lesbian, gay, bisexual, and transgender (LGBT) persons in Bangladesh. These were (1) to decriminalise same-sex relationships by abolishing Section 377 of the Bangladesh Penal Code, (2) to educate law enforcers and judicial officers about LGBT issues, and (3) to adopt further measures to ensure the protection of LGBT persons against violence and abuse. The government, however, accepted the recommendation of training law enforcers to protect sexual and gender minorities. The first two recommendations were rejected on the basis that "Bangladesh is a society with strong traditional and cultural values. Same-sex activity is not an acceptable norm to any community in the country."

The Government of Bangladesh has recognized intersex persons as a third gender. This has been approved in Cabinet meeting of GoB on 11 November 2013 and Gazetted, recognizing Hijras as a separate identity within the population in order to ensure they receive equal rights like other citizens of the country.

3. Recommendations

In spite of successes in health indicators, challenges remain in achieving universal access to reproductive health, in part because of the persistent unmet need for family planning, especially among unmarried adolescents. More broadly, the agenda for health is changing in a number of important ways that have a bearing on priorities for development and among the many goals of the newly identified Sustainable Development Goals (SDGs), Goal 5 is dedicated to gender equality and empowerment of women and girls. Gender-based violence, which was not addressed in the MDGs, is also emerging as a basic health issue. To improve the SRHR situation, government ministries, national and international organizations need to work more closely. Media has a role to play, to inform and create awareness on rights and ways to avail services. Human rights organizations, researchers and civil society should work together to attain and improve the following SRHR issues.

i. Ensure the recognition of sexual and reproductive health as fundamental rights and women and girls are rights holder

ii. Ensure universal right to access sexual and reproductive health services, with special emphasis on access by marginalised groups in particular rural women, young people, and excluded groups like-sex workers, sexually diverse groups such as homosexual, Bisexual, Transgender and Intersex(LGBTI) and women with disabilities, domestic workers

iii. Regulate birthing facilities to ensure respect for women's autonomy, privacy and dignity, including respect for women's choice regarding home delivery provided there are no specific medical contraindications

iv. Institutionalise women's autonomy in seeking sexual and reproductive health care services by removal of barriers, e.g. spousal, parental, or guardian consent

v. Ensure Medico Legal examination at district and sub-district (upazila) level hospitals through 24/7 emergency services

vi. Ensure enforcement of the Child Marriage Restraint Act 1929, amended in 1984 to reduce maternal and perinatal mortality: to enforce the legal processes to stop child marriage implementation of on-line birth registration across the country, strengthen national child protection systems, which are vital to helping prevent and respond to child marriage. Affidavits for the purposes of certifying age should not be acceptable

vii. Review and ratify laws policies according to the international treaties such as-CEDAW, ICCPR, ICESCR, and commitments such as-Beijing PFA, ICPD PoA with regard grievance redress mechanisms for SRH services for all people

viii. Repeal restrictive laws and policies in relation to termination of pregnancy, especially in cases of risk to the life or health, including the mental health, of the pregnant woman, rape, incest and fatal impairment of the fetus, recognizing that such laws and policies in any case primarily affect women living in poverty in a highly discriminatory way

ix. Include Sexual and Reproductive Health and Rights related issues in training of TBAs according to the commitments of ICPD and CEDAW

x. Ensure universal access to comprehensive sexuality education in the schools and colleges. Family members and elderly groups should also know the rights and existing services to get information and services of SRH issues

xi. Access to a quick and skilled integrated health care of Emergency Obstetric Care (EmOC) and complicated health care during pregnancy, delivery and post partum period to save the life of pregnant women

xii. Ensure transparency and accountability at all level

5. Conclusion

There is still much to be done in creating universal access to Sexual and Reproductive Health and Rights (SRHR). 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 programs 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 reference to specific SRH indicators.

Strong implementation and necessary institutional arrangements for recognizing, promoting, protecting, and fulfilling SRHR of women are essential. Access to services and information, supportive laws and legislation, specifically laws and policies regarding grievance redress mechanisms for SRH services and increased acceptance of sexuality and sexual rights of all people, are essential. Special intervention for reducing sexual and gender based violence need to be accelerated. Adolescents and young should be the main target group. Stronger and effective coordination within the public sectors and between the public and private sectors is required.

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GLOSSARY

Infant mortality: the probability of dying before the first birthday;

Child mortality: the probability of dying between the first and fifth birthday;

Under-5 mortality: the probability of dying between birth and the fifth birthday

Neonatal mortality: the probability of dying within the first month of life;

Postnatal mortality: the difference between infant and neonatal mortality;

Perinatal deaths: pregnancy losses occurring after seven completed months of gestation (stillbirths) and deaths within the first seven days of life (early neonatal deaths); whereas, stillbirths refer to fetal deaths in pregnancies lasting seven or more months; Early neonatal deaths are deaths at age 0 to 6 days among live-born children;

Total Fertility Rate (TFR): the total fertility rate is defined as the total number of births a woman would have by the end of her child bearing period if she were to pass through those years bearing children at currently observed Age-Specific Fertility Rates (ASRs);

Contraceptive Prevalence Rate (CPR): the percentage of couples who are currently using any method of contraception in among the total number of married women of reproductive age.

Unmet need for contraception: Sexually active women who are not currently using a method of family planning and want to stop or postpone child bearing are defined to have an unmet need for family planning.

Adolescent birth rate: The average number of births by women between the ages of 15 and 19 in a given year.

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 contributed by the membership. Naripokkho's work is focused on the following five 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.

Naripokkho's campaigns, projects and advocacy interventions are conducted by members with the support of full-time 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 achieved a strong reputation of expertise in gender and rights issues.

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